Section One - Introduction

1.1 Introduction

On August 22, 2000, the federal Health Care Financing Administration (HCFA) approved Minnesota's request to incorporate a second phase into the MinnesotaCare Health Care Reform Waiver (also known as the Prepaid Medical Assistance Project Plus (PMAP+) Demonstration Project).

This document is the operational protocol for the PMAP+ Demonstration Project – a description of how the State of Minnesota has implemented earlier phases of this project and how the State will implement Phase 2.

1.2 Prepaid Medical Assistance Demonstration Project

For more than fifteen years, Minnesota's Medicaid Program (Medical Assistance or MA) has administered a § 1115 waiver, allowing for the purchase of coverage from health plans on a prepaid capitated basis. This purchasing project, known as the Prepaid Medical Assistance Program (PMAP), was originally limited to a few Minnesota counties. The project required that nondisabled MA recipients be enrolled with a health plan, and remain enrolled with that plan for a 12-month period. See Section 2.2.1 for a detailed history of PMAP.

1.3 Phase 1 of the MinnesotaCare Health Care Reform Waiver

On April 27, 1995, HCFA approved a statewide health reform amendment to the PMAP waiver. With subsequent extensions and the Phase 2 amendment, the waiver is effective through June 30, 2002. Generally, Phase 1 allowed for the statewide expansion of PMAP, simplified certain MA eligibility requirements, and incorporated MinnesotaCare coverage for pregnant women and children with income at or below 275 percent of the federal poverty guidelines (FPG) into the Medicaid Program. An amendment approved on February 22, 1999, expanded this to include parents enrolled in MinnesotaCare. See Section 2.2.2 for a brief history of Phase 1.

1.4 Phase 2 of the MinnesotaCare Health Care Reform Waiver

In March 1997, the State proposed an amendment to Phase 1 of the MinnesotaCare Health Care Reform Waiver. In keeping with Minnesota's goal of continuing to reduce the number of Minnesotans who do not have health coverage, the State requested that HCFA authorize a second

phase of provisions that had been enacted by the Minnesota Legislature. On August 22, 2000, HCFA approved most aspects of Minnesota's Phase 2 amendment request, as described in the following section.

1.5 Components of the Waiver

1.5.1 Phase 1 – Medical Assistance Eligibility & Coverage

- MA eligibility for all **pregnant women** is determined using an income standard of 275 percent of the federal poverty level (FPL) with no asset standard, and with the full Medical Assistance (MA) benefit set. See Section 4.1 for a detailed description of implementation of this provision.

- MA eligibility is extended for **one month for managed care enrollees** determined ineligible for not submitting a completed household income report form or an eligibility re-determination form. See Section 4.2 for a detailed description of implementation of this provision.

- An **infant** who would otherwise be automatically MA eligible from birth to age one is automatically eligible through the month in which the child becomes age two, without any reevaluation of eligibility, if the child's mother was determined eligible while pregnant with the child or retroactively eligible on the date of the child's birth, as long as the child continues to live with the mother. See Section 4.3 for a detailed description of implementation of this provision.

- MA eligibility for **children under age two** is determined using an income standard of 275 percent of FPG with no asset standard. See Section 4.4 for a detailed description of implementation of this provision.

- The **Medicaid eligibility quality control** program is administered consistent with the *Pilot Project to Redesign Quality Control in Minnesota,* focusing on program review that can be utilized as a management analysis tool. See Section 4.5 for a detailed description of implementation of this provision.

1.5.2 Phase 2 – Medical Assistance Eligibility & Coverage

Eligibility administration is simplified by:

- Moving from **6-month income eligibility reviews** to 12-month reviews for people with only unvarying unearned income or excluded income. See Section 4.6 for a detailed description of implementation of this provision.

- Eliminating quarterly income reporting requirements for **extended MA recipients**. See Section 4.7 for a detailed description of implementation of this provision.

- Excluding from countable income **gifts of money** that do not exceed $100 per month. See Section 4.8 for a detailed description of implementation of this provision.

- Postponing the eligibility review for **postpartum women** who were receiving MA in another category prior to pregnancy and permitting them to retain eligibility in the former category until the household's next regularly scheduled review date. See Section 4.9 for a detailed description of implementation of this provision.

1.5.3 Phase 1 – Medical Assistance Purchasing & Service Delivery

- Comprehensive managed care under the **Prepaid Medical Assistance Program (PMAP)** has been expanded geographically. PMAP provides coverage of all MA state plan services – except home and community-based waiver, nursing facility (NF) beyond the first 90 days, intermediate care facility for people with mentally retardation (ICFs/MR), and abortion services; certain school-based services; and targeted case management services – through a managed care organization to most nondisabled MA recipients in the counties where it is implemented. See Section 8.2 for a detailed description of implementation of this provision.

- PMAP is authorized to **mandatorily enroll** MA recipients living in Itasca County whose basis of eligibility is blindness or disability, and MA recipients known as the TEFRA population. See Section 1.5.4 concerning a delay in implementation of this provision.

- Mental health services for a child who is, or is at risk of becoming, severely emotionally disturbed and who is not receiving comprehensive managed care under PMAP may be provided, as a voluntary option, through local **children's mental health collaboratives** under a prepaid, risk-based arrangement. See Section 8.3 for a detailed description of implementation of this provision.

- **Dental services** for MA recipients who are not receiving comprehensive managed care under PMAP may be provided on a prepaid, capitated basis.[1]

[1] This provision was amended in Phase 2 to prepaid carve-out of dental services from PMAP.

- Cost-based payment rates for federally-qualified health centers (FQHCs) and rural health clinics (RHCs) were being phased-out after a 3-year transition period beginning with their designation as essential community providers.[2]

1.5.4 Phase 2 – Medical Assistance Purchasing & Service Delivery

The population that may be mandatorily enrolled in PMAP has been expanded to include:

- Recipients in Itasca County who live near the county border and who use providers in a neighboring county.
- Children in foster care placements.
- Children eligible for MA through subsidized adoption.
- Individuals who have private HMO coverage.
- American Indians living on a reservation.

See Section 8.2.2 for a detailed description of implementation of this provision.

The population that may voluntarily enroll in PMAP has been expanded to include:

- Adults with serious and persistent mental illness.
- Children with severe emotional disturbance.

See Section 8.2.2 for a detailed description of implementation of this provision.

- MA recipients who are American Indians or Alaska Natives (whether living on and off of a reservation) will be enrolled in PMAP; services provided out-of-network by Indian Health Service or specified tribal providers will be covered on a fee-for-service basis. See Section 8.2.3 for a detailed description of implementation of this provision.

[2] This provision was withdrawn following enactment of the federal Balanced Budget Act of 1997 and subsequent state legislation that restored a percentage of cost-based reimbursement.

- PMAP coverage is expanded to include 90 days of **nursing facility services**. See Section 8.2.3 for a detailed description of implementation of this provision.

- A portion of PMAP payment rates associated with **medical education** will be carved out and distributed to teaching entities through the statewide medical education and research trust fund. See Section 8.2.8 for a detailed description of implementation of this provision.

- **Dental services** may be purchased on a capitated basis, separate from PMAP. See Section 8.2.8 for a detailed description of implementation of this provision.

- **PMAP enrollment of recipients with a disability** in Itasca County and children eligible under the TEFRA option will be postponed.

1.5.5 Phase 1 – MinnesotaCare Eligibility & Coverage

- **Federal Medicaid funding** is claimed for uninsured children, pregnant women, and parents and caretaker adults eligible for the MinnesotaCare Program with an income standard of 275 percent of FPG. Federal funding began July 1, 1995, for children and pregnant women, and March 1, 1999, for parents and relative caretakers.[3] Services covered for children and pregnant women are the same as those of the MA program. Services for parents and relative caretakers are less comprehensive, with copayments for prescription drugs, eyeglasses, and dental care, as well as other service limitations. See Sections Five and Seven for a detailed description of implementation of this provision.

1.5.6 Phase 2 – MinnesotaCare Eligibility & Coverage

- An **asset test** of $30,000 for a household of two or more will be applied to parents. See Section 5.3.1 and 5.3.5 for a detailed description of implementation of this provision.

1.5.7 Phase 1 – MinnesotaCare Purchasing & Service Delivery

[3] Minnesota began claiming FFP for parents and caretaker adults with income at or below 175 percent of FPG for services provided on or after March 1, 1999. For parents and caretaker adults with income above 175 percent of FPG and at or below 275 percent of FPG, Minnesota will begin claiming FFP for services provided on or after January 1, 2001.

- MinnesotaCare services are delivered through managed care organizations with payment on a capitated basis. See Section 9.1 for a detailed description of implementation of this provision.

1.5.8 Phase 2 – MinnesotaCare Purchasing & Service Delivery

- Dental services may be purchased on a capitated basis, separate from Prepaid MinnesotaCare. See Section 9.2 for a detailed description of implementation of this provision.

Section Two - Background and History

2.1 Minnesota's Current Health Care Programs for Low-Income People

Minnesota currently provides coverage of health care services for more than one-half million low-income, uninsured, and special needs individuals through the Medical Assistance (MA), General Assistance Medical Care (GAMC), and MinnesotaCare programs.

2.1.1 Medical Assistance Program

Minnesota administers the MA Program under title XIX of the Social Security Act. The program covers health care services that address acute, chronic and long-term care needs for nearly 400,000 residents. Eligibility requirements for the program are set forth in the State's Medicaid plan, in home- and community-based services waivers, and in this waiver.

Prepaid Medical Assistance Program. Approximately 184,000 MA recipients receive services through prepaid managed care plans under the State's current §1115 waiver for the Prepaid Medical Assistance Program (PMAP). The remaining recipients receive services from enrolled providers who are paid on a fee-for-service basis. Services not included in PMAP are purchased on a fee-for-service basis. For a history of PMAP, see Section 2.2.1.

Minnesota Senior Health Options. MSHO integrates long-term care and acute care services under combined Medicare and Medicaid capitation payments for elderly Medicare recipients who are on Medicaid. Enrollment in MSHO began in March 1997 under a §1115 Medicaid demonstration project waiver and a §402 Medicare payment waiver. Authority for MSHO has since been converted to §1915(a) for the Medicaid aspect of the project.

Other waivers. In addition, the State currently operates its Medicaid program with six §1915(c) home- and community-based services waivers and one §1915(b) freedom-of-choice waiver:

- §1915(c) waiver for people with mental retardation or related conditions (MR/RC Waiver) who are at risk of requiring services in an ICF/MR.
- Community Alternatives for Disabled Individuals (CADI) §1915(c) Waiver for people with a disability who are at risk of requiring nursing facility services.
- Community Alternative Care (CAC) §1915(c) Waiver for chronically ill people who are at risk of requiring inpatient hospitalization.
- Traumatic Brain Injury (TBI) §1915(c) Waiver for people with traumatic brain injury who are at risk of requiring nursing facility services or inpatient hospitalization.

- §1915(c) Elderly Waiver for people age 65 or older who are at risk of requiring NF services.

- Consolidated Chemical Dependency Treatment Fund (CCDTF) §1915(b) Waiver permits the State to restrict freedom of choice of chemical dependency treatment services for recipients who are not enrolled in PMAP. Local county agencies and Indian reservations act as case managers, doing assessments and referrals for chemical dependency treatment.

2.1.2 General Assistance Medical Care Program

GAMC is a state-funded program that covers acute and non-long-term health care for an average of approximately 23,000 Minnesota residents who are not categorically eligible for MA but who meet income and asset requirements comparable to the medically needy standards and methodologies of the MA Program. GAMC has provided coverage to Minnesotans since 1973.

Services are provided to approximately 13,000 GAMC recipients through prepaid managed care. As with MA, the remainder receive services from enrolled providers who are paid on a fee-for-service basis.

2.1.3 MinnesotaCare Program

MinnesotaCare is a state- and federally-funded program that primarily covers acute care services for approximately 128,000 uninsured Minnesotans, including approximately 103,000 individuals in families with children whose family income does not exceed 275 percent of FPG and approximately 25,000 adults without dependent children whose income does not exceed 175 percent of the FPG. FFP is claimed for approximately 102,000 enrollees. Families are permitted to exceed 275 percent once they are in the program, but the family must pay full premium. No FFP is claimed for expenditures for these enrollees. If 10 percent of the family's gross income is equal to or more than the Minnesota Comprehensive Health Association premium, the family will lose MinnesotaCare in 18 months.

Children and pregnant women enrolled in the MinnesotaCare Program receive coverage equivalent to MA coverage under Minnesota's Medicaid state plan. Coverage for other MinnesotaCare enrollees is less comprehensive, with copayments for prescription drugs, eyeglasses, and dental care, as well as other service limitations. MinnesotaCare enrollees receive coverage through prepaid health plans.

To be eligible for MinnesotaCare, individuals generally may not otherwise have been insured for four months prior to application and may not have been offered employer-subsidized insurance coverage for 18 months prior to application. Enrollees pay a premium for MinnesotaCare

coverage based on a sliding scale related to family income.

Federal Medicaid funding is claimed for uninsured children, pregnant women, and parents and caretaker adults eligible for the MinnesotaCare Program with an income standard of 275 percent of FPG. Federal funding began July 1, 1995, for children and pregnant women, and effective March 1, 1999, for parents and caretaker adults.[4]

2.2 History of the MinnesotaCare Health Care Reform Waiver

2.2.1 History of PMAP

PMAP was one of five original demonstration projects authorized by HCFA under §1115 of the Social Security Act to implement managed care for non-long term care services for designated Medicaid populations on a prepaid, capitated basis. In the early 1980s HCFA solicited states to examine cost effective alternatives for payment and delivery of MA services. Based on an application submitted in April 1982, Minnesota was awarded a grant to fund the design of PMAP.

State legislation enabling the design and implementation of PMAP was enacted in 1983. The PMAP design evolved from an advisory committee process. The State assembled a committee representing the State, counties, providers, health maintenance organizations (HMOs), advocates, and consumer representatives. The committee actively participated in decisions regarding PMAP implementation and assisted in writing the program protocol that was submitted to HCFA. This committee process was followed by lengthy county-specific task force processes in Dakota and Hennepin Counties, enabling each county to lay out requirements for the project.

Decision makers in both Itasca and Dakota counties were eager to participate in the experiment and volunteered to be the rural and suburban sites respectively. Securing an urban site was more difficult. Hennepin County's human services agency had indicated an interest in participating as the urban site, but the county board expressed reservations about the program. After efforts on the part of the State and the Hennepin County Board to address their concerns, the Board voted to participate as the urban site for PMAP.

[4] Minnesota began claiming FFP for parents and caretaker adults with income at or below 175 percent of FPG for services provided on or after March 1, 1999. For parents and caretaker adults with income above 175 percent of FPG and at or below 275 percent of FPG, Minnesota will begin claiming FFP for services provided on or after January 1, 2001.

Section Two - Background and History

The program protocol was submitted to HCFA in March 1985. Preliminary HCFA approval was obtained on July 10, 1985. Final HCFA approval of the operational phase of the project was granted on December 6, 1985.

Itasca County implemented PMAP on July 1, 1985. Implementation of the program was delayed until December 1985 for the Dakota and Hennepin County sites due to complications. In Hennepin County, 35 percent of the MA population was originally enrolled in PMAP, with 65 percent remaining fee-for-service to provide a control group for research purposes. Except for populations specifically excluded, those in the control group could voluntarily enroll with a health plan. The voluntary enrollment occurred outside of the confines of PMAP, but was handled in a very similar manner. The demonstration period was to run until December 31, 1988, providing for three years of experience for Dakota and Hennepin Counties and three and one-half years for Itasca County.

The populations initially covered by PMAP included families with children, elderly, and persons with chronic mental illness or physical disabilities (including blindness) who were recipients of MA without a spend down. Health plans were given the option of enrolling only one MA population, but the State stipulated that any health plan contracting to serve Aid to Families with Dependent Children (AFDC) recipients would also be required to serve one of the higher risk elderly or disabled populations.

The Blue Cross and Blue Shield (BCBS) Sun Series Plan withdrew from participation in PMAP effective January 1, 1988. Because over half of the blind and disabled population were enrolled with BCBS, the State had serious concerns about disruption of continuity of care should enrollees be required to enroll with a different health plan. In addition, operational and model design issues related to PMAP enrollment for persons with developmental disabilities had not yet been resolved. Therefore, the Department disenrolled the blind and disabled populations from PMAP by December 31, 1987.

Difficulty in obtaining usable service encounter data made it difficult to evaluate the initial Phases of the project. In addition, delays in enrollment resulted in considerably less than three years of actual program experience. Thus, in the summer of 1987, the State requested that a two-year extension of the project be granted. HCFA denied the request for an extension in September 1987, encouraging the State to instead transition to a §1915(b) waiver.

The State pursued two courses of action: approval of a §1915(b) waiver and a two-year extension of the §1115 waiver through congressional action. A §1915(b) waiver application was completed and submitted to HCFA in August 1988. The State considered the §1115 waiver extension crucial to continuation of the program because there was an insufficient health plan interest in participating under the §1915(b) waiver option. One of the features of the §1115 program design considered critical by the health plans is the 12-month recipient lock-in to a

given health plan. §1915(b) did not provide for this feature. Without a 12-month lock-in, enrollees could change health plans from month-to-month. Health plans were concerned about their financial risk and consumer outcomes in this scenario.

Several health plans had dropped voluntary AFDC managed care contracts. Lack of enrollment stability in this program contributed greatly to health plan dissatisfaction. The 12-month consumer lock-in provided them with greater financial stability, with greater assurance of a few months' premium for a given enrollee and an opportunity to provide preventive services.

In July 1988, the State requested that health plans submit a letter of intent to participate under either the §1115 waiver or the §1915(b) waiver programs. Physicians Health Plan (PHP), a participating health plan, indicated they would not participate under the §1915(b) waiver option, and other health plans, particularly PreferredOne, expressed strong reservations about participating without the flexibility of the §1115 waiver authority. The State considered recipient access to be inadequate without PHP's participation. Thus, only the §1115 waiver option was considered viable.

During the same period, Minnesota succeeded in obtaining congressional authority to extend the §1115 waiver. Initially, the Family Support Act of 1988 extended the waiver until June 30, 1990[5]. This authority was subsequently amended by the Omnibus Budget Reconciliation Act of 1989 to extend the waiver to June 30,1991[6].

State authority was granted by the 1989 Minnesota Legislature to expand PMAP to other counties designated by the State. In the fall of 1989, the Hennepin County Board of Commissioners recommended that the State pursue the expansion of PMAP to other Hennepin County MA populations. With HCFA approval, the expansion effort began in July of 1990, and the remaining eligible Hennepin County MA populations were enrolled in PMAP by the end of December 1991.

In October of 1990, Congress granted authority under the Omnibus Budget Reconciliation Act of 1990 to extend PMAP through June 30, 1996[7]. Under this authority, Minnesota was permitted to expand PMAP to other viable counties.

[5] Public Law 100-485, §507.

[6] Public Law 101-239, §6411(j).

[7] Public Law 101-508, §4733.

Expansion of PMAP to Ramsey County. With the demonstrated success of PMAP in Hennepin, Dakota, and Itasca Counties, and the state legislative authority to expand the program, the State began to examine expansion into other counties. Because it has the second largest MA population in the state situated within a relatively small geographic area, Ramsey County was selected as the next PMAP expansion region. PMAP implementation in Ramsey County began April 1, 1993, and enrollment occurred gradually over a one- year period.

Expansion of PMAP to Anoka, Carver, Scott, and Washington Counties. In determining where PMAP would subsequently be implemented, the Department examined a number of variables related to accessibility, geographic location, current utilization patterns, the size of the potential population, and the number of potential health plan contractors. To assess health plan interest in serving the MA populations in thirteen Minnesota counties, including the four PMAP counties, the Department issued a request for interest (RFI) in July 1993. After review of the RFI responses and evaluating the options, the Department focused on expanding PMAP into the four remaining counties of the seven-county Twin Cities metropolitan area: Anoka, Carver, Scott, and Washington. The Department held several planning sessions with county administrators, held information sessions for providers, and provided extensive training for expansion county staff in preparation for PMAP implementation. In December 1993, the Department issued a request for proposals (RFP) to serve MA recipients in all seven metropolitan counties. After evaluation of the responses, six health plans were chosen to participate in PMAP in the seven county metropolitan area. PMAP enrollment in Anoka, Carver, Scott, and Washington Counties began in September 1994 and was completed in October 1995. Prepayment expansion under the state-funded GAMC Program was implemented simultaneously.

Expansion of PMAP to the Central and Northeast Regions of Minnesota. In 1995 the Department selected the central and northeast regions of Minnesota for PMAP expansion. The April 27, 1995 approval of Phase 1 of the MinnesotaCare Health Care Reform Waiver provided approval for statewide expansion of PMAP, including specific approval for expansion to the central and northeast regions.

To address county-specific issues and concerns related to PMAP, and to assure a smooth transition to managed care, county development teams were again formed in the new regions. These teams included department staff and county supervisors representing social services, public health, and income maintenance in each county. The department also provided technical assistance and training in the expansion counties during the PMAP preparation phase and throughout the first year of implementation. In June 1995, the Department issued an RFP for prepaid health plans to provide MA coverage in Stearns, Benton, and Sherbume Counties in central Minnesota and to the northeast region of the state. Counties included in the northeast expansion, where a regional approach to managed care was taken, include Carlton, Cook, Koochiching, Lake, and St. Louis.

Section Two - Background and History

After evaluating the RFP responses, obtaining county input, and conducting the contract negotiation process, the Department selected several health plan contractors for the expansion counties: Blue Plus, Central Minnesota Group Health, First Plan, Itasca Medical Care, Medica (formerly Physicians Health Plan), and UCare Minnesota. PMAP enrollment in the central and northeast expansion areas began January 1, 1996, and enrollment was completed prior to the end of 1996.

Expansion of PMAP to further Rural Regions of Minnesota. PMAP has been expanded to additional counties in Minnesota – primarily in rural regions – in accordance with the following table.

Date PMAP Enrollment Began	Geographic Region
July 1985	Itasca County
December 1985	Dakota and Hennepin counties
April 1993	Ramsey County
September 1994	Anoka, Carver, Scott, and Washington counties
January 1996	Benton, Carlton, Koochiching, Lake, Sherburne, Stearns, and St. Louis counties
August 1996	Cook County
January 1997	Wright County
June 1997	Clay, Mahnomen, Faribault, Martin and Isanti counties
July 1997	Becker County
September 1997	Kandiyohi and Swift counties
October 1997	Norman County
January 1998	Chisago County
June 1998	Aitkin County
August 1998	Chippewa, Cottonwood, Jackson, Lincoln, Lyon, Murray, Nicollet, Nobles, and Rock counties
September 1998	Fillmore, Houston, Kittson, LeSeuer, Marshall, Pennington, Red Lake, Redwood, Roseau, and Watonwan counties

October 1998	Lac Qui Parle, Mille Lacs, and Yellow Medicine counties
January 1999	Ottertail, Wilkin, and Winona counties
July 1999	Rice County
August 1999	Pine County
January 2001	Cass, Crow Wing, Morrison, Todd, and Wadena counties

PMAP expansion in these regions involved work with local county development teams and county review of health plan bids and proposed provider networks. As of January 2001, PMAP will be enrolling recipients in sixty of Minnesota's eighty-seven counties.

Minnesota's Current Managed Care Environment. Minnesota's managed care market can be described as mature. Ten HMOs and one community integrated service network (CISN) operate in the state. About one-third of all insured Minnesotans (in both public and private programs) are covered by an HMO, and many others participate in plans that have some managed care features, such as prior authorization requirements and utilization review.

The State currently contracts with eight HMOs, one CISN, and one county-operated health insuring organization (HIO) – Itasca Medical Care – to provide managed care services to Medical Assistance enrollees in fifty-five counties, and MinnesotaCare enrollees in all eighty-seven counties.

2.2.2 Brief Overview of Phase 1 of the MinnesotaCare Health Care Reform Waiver

It is the goal of the State to make continuous progress toward reducing the number of Minnesotans who do not have health coverage. The goal will be achieved by improving access to private health coverage through insurance reforms and market reforms, by making health coverage more affordable for low-income Minnesotans through purchasing pools and state subsidies, and by reducing the cost of health coverage through cost containment programs and methods of ensuring that all Minnesotans are paying into the system according to their ability to pay.[8]

Phase 1 of the MinnesotaCare Health Care Reform Waiver was one of the first steps in conforming Minnesota's Medicaid Program to this overarching goal, with the complementary goals of:

[8] MINNESOTA STATUTES, §62Q.165, subd. 2 (1996).

- Demonstrating that access to affordable health care coverage can be provided without encouraging employers to discontinue coverage of employees.

- Demonstrating that there are more efficient methods of Medicaid Program administration than those required by federal statutes.

- Expanding the delivery of services through managed care for Medicaid recipients to improve access to quality care, to ensure appropriate utilization of services, to improve the continuity of care, to enhance patient and provider satisfaction, and to achieve cost efficiencies in the delivery of health care.

In July 1994, the Minnesota Department of Human Services and the Minnesota Department of Health submitted Phase 1 of the MinnesotaCare Health Care Reform Waiver for approval under §1115 of the Social Security Act. On April 27, 1995, the Secretary of Health and Human Services, Donna Shalala, approved the new waiver as an amendment to an earlier waiver (Prepaid Medical Assistance Project Waiver No. *ll-C-98223/5-12).* The new waiver, known formally as the Prepaid Medical Assistance Project Plus (PMAP+) Waiver No. ll-W-00039/5, extended the earlier project from July 1, 1996 to June 30, 1998 and focused on two primary areas:

- Integration of publicly funded health care programs for low-income, uninsured, and special needs populations.

- Expansion of purchasing through care delivery networks for publicly funded health care programs.

This waiver was extended twice – once to June 30, 1999, and subsequently to June 30, 2002.

2.2.3 History of Eligibility and Benefits Changes

By the early 1990s, Minnesota was providing coverage to nearly half a million individuals through three publicly funded programs: MA, GAMC, and Children's Health Plan (CHP). Minnesota's MA Program was fairly comprehensive in terms of coverage of eligibility groups and benefits. The state-funded GAMC Program was designed to provide acute and non-long term care coverage to individuals who were not categorically eligible for MA, but who met the income and asset requirements comparable to the medically needy standards and methodologies of the MA Program. The state-subsidized CHP provided coverage of most acute services (excluding inpatient hospitalization) for uninsured children who were ineligible for MA, but who were part of families with income at or below 185 percent of the FPG. Payment of a relatively small annual premium was required for coverage under CHP.

Section Two - Background and History

Comprehensive health reform measures were enacted by the Minnesota Legislature in 1992, 1993, and 1994. The fundamental goal of the reform measures was to ensure the provision of quality, affordable, and accessible health care for Minnesotans. As such, it was necessary to include Minnesota's publicly funded health care programs in the comprehensive reform process. One such measure included the 1992 implementation of the MinnesotaCare Program for uninsured families with children (as an expansion of CHP). MinnesotaCare initially provided coverage of families with income at or below 185 percent of FPG and was expanded in January 1993 to include families with income at or below 275 percent of FPG. The intent was to provide coverage of non-long term care services for working poor families who had no access to affordable insurance coverage. Provisions were made to prevent the erosion of private sector coverage of this population, including a $10,000 annual limit on inpatient hospital coverage for adults; a requirement that individuals not be otherwise insured for four months prior to application; and a requirement that individuals must not have been offered employer-subsidized insurance coverage for 18-months prior to application. These provisions do not apply to children under 150% of FPG. Enrollees pay a premium for MinnesotaCare coverage based on a sliding scale related to family income. The MinnesotaCare Program was expanded again in October 1994 to provide coverage of uninsured adults without children who have family incomes at or below 125 percent of FPG, in July 1996 to increase the standard to 135 percent of FPG, and in July 1997 to 175 percent of FPG.

In 1992, Minnesota discontinued the MA program asset test for all children under the age of 21, and in 1993, expanded MA eligibility to include infants and pregnant women with incomes below 275 percent of FPG, and discontinued the asset test for all families with children. In 1997, the Minnesota Legislature reinstated the asset test in MA for families and children. The 1997 Legislature also enacted an asset test in MinnesotaCare for parents and children, but not for pregnant women. In 1998, the Legislature eliminated the asset test for children in both MA and MinnesotaCare.

The April 27, 1995 approval of Phase 1 of the MinnesotaCare Health Care Reform Waiver allowed Minnesota to implement a number of minor expansions to MA eligibility and benefits and to obtain federal Medicaid funding for coverage of children and pregnant women enrolled in the MinnesotaCare Program for Families with Children.

In 1998, Minnesota implemented a very small State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act. Federal SCHIP maintenance of effort provisions prevented Minnesota from accessing enhanced SCHIP funding for children below 275 percent of FPG, and HCFA denied Minnesota's request for an SCHIP §1115 waiver. Because federal law required states to have an approved SCHIP plan to preserve the first year of their SCHIP allotment, the State implemented a minor expansion in MA to cover children under age two with family income between 275% and 280% of FPG. Expenditures for these children are eligible for federal SCHIP match.

2.2.4 Phase 2 of the MinnesotaCare Health Care Reform Waiver

To continue our progress toward reducing the number of Minnesotans who do not have health coverage, HCFA approved an amendment to Phase 1 of the MinnesotaCare Health Care Reform Waiver. The amendment will permit further integration of publicly-funded health care programs for low-income, uninsured, and special needs populations; further support Minnesota's "work pays" approach to welfare reform; and expand purchasing of coverage through care delivery networks. The components of the Phase 2 waiver request are the result of legislation enacted by the Minnesota Legislature in 1995 and 1996 to further the goals of the Phase 1 waiver.

Section Two - Background and History

Section Three — Administrative Structure

3.1 Introduction

Three state agencies have oversight responsibilities for some aspects of Minnesota's Medicaid program:

- Minnesota Department of Human Services (DHS)
- Minnesota Department of Health (MDH)
- Minnesota Department of Commerce.

In addition, counties play a significant role in administering some aspects of PMAP.

3.1.1 Department of Human Services' Role

DHS is the single state Medicaid agency responsible for purchasing health services for Medical Assistance (MA) and MinnesotaCare enrollees. DHS' Health Care Administration supervises administration of MA eligibility at the county level, administers the MinnesotaCare Program at the state level, purchases covered services, and provides for performance measurements and quality improvement of health care administration and service delivery for program enrollees.

Medical Assistance Eligibility. MA Eligibility is supervised by DHS Health Care Administration and is administered by local county agencies.

MinnesotaCare Eligibility. MinnesotaCare eligibility is primarily administered by DHS Health Care Administration.

PMAP Purchasing. PMAP is administered by DHS Health Care Administration. State PMAP administration includes the following functions:

- Contract negotiation and management.
- Rate setting and financial management.
- Quality improvement, utilization review, and consumer satisfaction analysis.
- Program evaluation.
- Management of the appeals process.
- Oversight of the consumer education process.
- Health plan payment.
- Reporting to health plans (e.g., enrollment reports).
- Education of providers, health plans, advocates, and other interested groups.
- Coordination of the Office of Ombudsman and coordination of advocate activities.
- Coordination of the advocate network.

- Coordination with county project officers.
- Policy setting and dissemination.
- Promulgation of rules.

MinnesotaCare Purchasing. Prepaid MinnesotaCare is administered by DHS Health Care Administration.

3.1.2 Department of Commerce Role

DOC is the state agency responsible for financial and solvency monitoring, regulation, rehabilitation, and liquidation of all health plans licensed or applying for licensure in Minnesota.

The Insurance Division of the Department of Commerce is responsible for assuring policyholders are protected against financially unsound insurance companies, and from unfair and discriminatory business practices.

Field examiners visit insurance companies to conduct on-site reviews of financial and operations records. Analysts study the data to evaluate the financial status of the companies. The commissioner may authorize additional investigations or take administrative actions when appropriate.

3.1.3 Department of Health Role

MDH provides consultation to DOC on issues of health care, including medical necessity, quality of care, and access to care.

The department operates programs in disease prevention and control, health promotion, community public health, environmental health, health care policy, and regulation of health care providers.

3.1.4 County Role

Counties are responsible for administering eligibility for MA and GAMC. In some cases, counties also administer MinnesotaCare eligibility. County agencies are also responsible for the following PMAP administrative functions:

- Consumer education and recipient enrollment.
- Coordination of the project at the county level including training of county workers.
- Monitoring and evaluation of the project from the county's perspective.
- Project reporting to the county board and county advisory groups.

- Information and technical assistance on the project to county staff, community and provider organizations, and the general public.
- Identifying and responding to problem areas and problem cases.
- Providing input to DHS in the development of PMAP policy.
- Advocating for recipients who need assistance with accessing health care or with the appeal process.

In addition, counties have other health and human services responsibilities related to their role as the local public health, mental health, chemical dependency, and developmental disability authority.

3.2 Organizational Structure of the Minnesota Department of Human Services

3.2.1 DHS Commissioner

Michael O'Keefe is Commissioner of Human Services and is responsible for directing the activities of the Department, which include the publicly funded health care programs.

Tom Moss is the Deputy Commissioner of Human Services.

3.2.2 DHS Health Care Administration

Health Care administers the State's health care assistance programs, including program eligibility and purchasing policies and negotiations between state health care programs and health plans.

Mary Kennedy, Assistant Commissioner of Health Care Administration, is responsible for the publicly-funded health care programs. She also serves as State Medicaid Director.

The Medicaid director administers policy for the federal Medicaid program in Minnesota (called Medical Assistance), including serving as liaison to the Health Care Financing Administration (HCFA).

Ann Berg is the manager of federal Health Care Financing Administration relations and federal Medicaid compliance.

Sandy Burge is manager of negotiations, waivers, and tribal relations.

Kathleen Vanderwall is responsible for designated §1115 waivers, including the MinnesotaCare Health Care Reform Waiver.

James Chase is the Director of Purchasing and Service Delivery. Purchasing and Service Delivery administers negotiations, contracting, purchasing and payment for PMAP and Prepaid MinnesotaCare, in addition to benefit design and rate-setting for fee-for-service purchasing.

Kathleen Henry is the Director of Health Care for Families with Children. This division is responsible for policy development and administers eligibility policy, training and education for the MinnesotaCare, MA, GAMC, and state prescription drug programs. The division supervises county administration of MA eligibility and administers MinnesotaCare eligibility.

Vicki Kunerth is Acting Director of Performance Measurement and Quality Improvement. This division researches and develops performance measures to evaluate DHS' health care programs. Activities include developing and maintaining health care data and information systems, conducting clinical focus studies, evaluating population health, administering satisfaction surveys, and establishing quality assurance and improvement standards for health care purchasing on behalf of public clients.

3.2.3 DHS Continuing Care Administration

Maria Gomez is Assistant Commissioner of Continuing Care. This administration is responsible for policy development and implementation related to MA and other funding sources for continuing care services provided to the elderly and people with disabilities. This includes responsibility for home and community-based §1915(c) waiver services for people at risk of requiring institutional care, nursing facility policy and rate setting, and ICF/MR policy and rate setting.

Bob Held directs the Continuing Care for the Elderly (CCE) Division of the Aging Initiative. This division oversees long-term care services for the elderly, including nursing facility and home and community-based services funded through DHS. Oversight includes eligibility, benefits, rate setting, preadmission screening, care system development, public health interventions, and administration of federal grants (waivers). The preadmission screening, alternative care and elderly waiver programs, as well as Rule 50 nursing facility rate setting and the contractual nursing home alternative payment system demonstration project, are all in CCE.

Pamela Parker is director of the Minnesota Senior Health Options (MSHO) program.

3.2.4 DHS Finance and Management Operations

Dennis Erickson is Assistant Commissioner of Finance and Management Operations. This administration is responsible for the human services infrastructure, which supports the department's two main business functions. This involves financial operations, legal and

regulatory processes and management services that support the entire agency.

Larry Woods is director of Health Care Operations. This area is responsible for the medical claims processing for the department's health care programs. It coordinates benefit payments with third party payers, handles special financial recovery activities and works with health care providers to assure prompt payment for services they provide. Health Care Operations uses the Medicaid Management Information System (MMIS) to do its work.

George Hoffman is the Director of Reports and Forecasts. This division is responsible for meeting federal reporting requirements for cash assistance, medical programs, and food stamps; providing forecasts for program caseloads and expenditures that are used in budget development; providing fiscal notes accompanying proposed legislation; and responding to requests for statistical information.

3.3 Organizational Structure of Minnesota Department of Commerce

Jim Bernstein is Commissioner of Commerce. He is responsible for directing the activities of the agency, including regulation of managed care plans.

Kevin Murphy is the Deputy Commissioner of Commerce for Financial Exams.

3.4 Organizational Structure of Minnesota Department of Health

3.4.1 MDH Commissioner

Jan Malcolm is Commissioner of Health. She is responsible for directing the activities of the agency, including regulation of managed care plans. The commissioner has general authority as the state's official health agency and is responsible for the development and maintenance of an organized system of programs and services for protecting, maintaining, and improving the health of the citizens of the State.

Julie Brunner is Deputy Commissioner of Health

3.4.2 Health Policy and Systems Compliance Division

Richard Wexler is Assistant Commissioner of Health.

Section Three — Administrative Structure

David Giese is Director of the Health Policy and Systems Compliance Division. This division assists in the development of state health policy, monitors the impact of health reform, and helps health care consumers deal with providers and a rapidly-evolving marketplace. The division works to ensure the quality of services provided by a wide range of health care providers and health care systems, and to protect the interests of health care consumers. Staff of the division accept and respond to consumer inquiries and complaints about providers, and investigate potential problems.

Kent Peterson is Manager of the Managed Care Systems Section. This section has responsibility for conducting financial audits and quality assurance reviews of regulated managed care plans. The section monitors health maintenance organizations, community integrated service networks, county-based purchasing, and accountable provider networks in Minnesota for quality of care, financial solvency, and compliance with state law.

Norm Hanson directs complaint investigations.

Irene Goldman directs compliance and enforcement activities.

Sue Margot conducts rule making and policy activities.

Connie Ventrelli conducts quality assurance monitoring.

Section Four —MA Eligibility

Under this demonstration waiver, eligibility for the MA Program is consistent with Minnesota's state plan and §1915(c) waivers except as provided for in this section. For information describing eligibility for the MinnesotaCare Program, see Section Five.

4.1 Coverage for Pregnant Women

Rather than requiring multiple eligibility determinations for qualified pregnant women, medically needy pregnant women, and categorically needy pregnant women, MA eligibility for all pregnant women is determined using an income standard of 275 percent of the FPG, with no asset test. Eligibility continues until the end of the month in which 60 days post-partum occurs. A woman must provide medical verification of her pregnancy within 30 days of enrollment as a pregnant woman.

Coverage for all pregnant women consists of the full MA benefit set for a qualified pregnant woman in accordance with §1902(a)(10)(A)(I)(iii).

This provision was implemented effective January 1, 1995.

4.2 One-Month Extended Eligibility for Managed Care Enrollees

MA eligibility for managed care enrollees determined ineligible for not submitting a completed household income report form or an eligibility redetermination form, in a timely manner, is extended one month to allow the enrollee to submit the form. To be eligible for the one month extension, the enrollee must be determined eligible for the program when the form is submitted. This provision is intended to reduce the administrative burden and lost continuity of care that occurs when an individual is determined ineligible for MA as a result of not submitting specified forms, but subsequently submits the forms and is determined to be eligible for the same period.

This provision was implemented effective March 1, 1996.

4.3 Newborns Automatically Eligible Until Age Two

An infant who is automatically MA eligible from birth to age one under §1902(e)(4) of the Social Security Act, remains automatically eligible through the month in which he or she becomes age two, without any reevaluation of eligibility, if the mother had been determined eligible while pregnant with the child, or the mother was retroactively determined to have been

eligible on the date of the child's birth, as long as the child continues to live with the mother.

This provision is intended to ensure that children receive postnatal and early childhood health care, such as immunizations, that is necessary to prevent the onset of more costly illness at a later age.

This provision was implemented effective July 1, 1995.

4.4 Children Under Age Two

MA eligibility for children under age two is determined using an income standard of 275 percent of FPG with no asset test. This extends the income standard of 275 percent of FPG that is applied to children under age one under the state plan, to include children under age two. This is an expansion of coverage under the state plan for children age one at 133 percent of FPG.

Like the automatic eligibility described above for children under age two, this provision improves access to postnatal and early childhood health care.

The provision was implemented effective July 1, 1995.

Note that an additional expansion has been instituted for children under age two with family income between 275 and 280 percent of FPG. The state plan provides for MA coverage for that population under the provisions of Title XXI, the State Children's Health Insurance Program.

4.5 Medicaid Eligibility Quality Control Program

The Medicaid Eligibility Quality Control Program is administered consistent with the *Pilot Project to Redesign Quality Control in Minnesota*. This project is an ongoing, flexible quality improvement initiative to evaluate the state's MA program. The pilot is central to the state effort to improve service to recipients, to improve access to eligibility for publicly funded health care programs, and to assure the integrity of the programs.

The pilot was originally approved for the period of October 1, 1994 to September 30, 1995 and later extended under this waiver.

Section Four —MA Eligibility

4.6 Elimination of Certain Six-Month Income Reviews

Six-month income reviews for medically needy recipients with only unvarying, unearned income or excluded income will be discontinued.

This provision will apply to medically needy recipient households who have only unvarying, unearned income. Unvarying, unearned income is defined as income from a source other than employment or self-employment that can reasonably be anticipated to be the same amount every month and for which changes, such as periodic cost-of-living increases, can be anticipated. Examples of this type of income include SSDI, Reemployment Insurance (Unemployment Compensation), veterans' disability payments, and private pensions. Data matches currently exist to allow direct verification of SSDI, SSI, and Reemployment Insurance. The State hopes to develop additional matches with other sources such as the Veterans Administration.

This provision will also apply to medically needy recipient households whose sole income is from a source excluded from consideration by law. Examples include federally excluded payments such as certain tribal payments, German war reparations, WIC benefits, and earnings of a minor household member who is a full-time student.

For these two groups, income reported at the time of application or annual review will be projected for 12 months. The amount of income reported will be assumed to be the same unless the recipient notifies the local agency of a change. The State will use data matches where available to monitor and verify changes. Although income reports will not be required, cases with spend downs will be reviewed every six months to insure that the recipient continues to have sufficient medical expenses to meet the spend down.

This provision will be implemented effective July 1, 2001.

4.7 Elimination of Quarterly Review for Extended or Transitional MA Recipients

Quarterly income reviews will no longer apply to transitional MA (TMA) recipients. In addition, the 185 percent of FPG income limit that normally applies during the second six months of the transitional eligibility period will be eliminated. Enrollees will be determined eligible for TMA once their increased earnings or loss of earned income disregard causes their countable income to exceed the 1931 standard. TMA will be provided to the household for a 12-month period or until there is no longer a dependent child in the household, whichever occurs sooner. There will be no income reviews conducted during the TMA eligibility period.

This provision will not be implemented until legislative authority is reinstated.[9]

4.8 Gift Income Exclusion

Gift income of less than $100 per month will be excluded from countable income for all MA eligibility groups. Such income will also not be required to be reported.

This provision will not be implemented until legislative authority is reinstated.[10]

4.9 Elimination of Certain Post-Partum Reviews

Women who were eligible under another basis before the pregnancy or who live with other eligible household members subject to the same basis and income limits will not have to reapply or have their eligibility reviewed until the household's next regularly scheduled review date after the end of the post-partum period.

This provision will be implemented effective February 1, 2002.

Section Five —MinnesotaCare Eligibility

5.1 Introduction Framework

The MinnesotaCare Program for Families with Children covers parents and their children in families with income up to 275 percent of the federal poverty guidelines (FPG). Effective July 1, 1995, expenditures for children under the age of 21 and pregnant women enrolled in MinnesotaCare became eligible for federal financial participation (FFP) as a part of Minnesota's expanded Medicaid Program. Effective February 27, 1999, expenditures for parents and caretaker adults enrolled in MinnesotaCare became eligible for FFP.

Minnesota began claiming FFP for parents and caretaker adults with income at or below 175 percent of FPG for services provided on or after March 1, 1999, and will begin claiming FFP for parents and caretaker adults with income above 175 percent of FPG and at or below 275 percent of FPG for services provided on or after January 1, 2001.

5.2 Definitions

5.2.1 Applicant. "Applicant" means a person who submits a written application to the Department of Human Services (DHS) for a determination of eligibility for MinnesotaCare.

5.2.2 Child. "Child" means a person who is less than 21 years of age.

5.2.3 Dependent sibling. "Dependent sibling" means an unmarried child who is a full-time student under the age of 25 years who is financially dependent upon a parent. Proof of school enrollment is required.

5.2.4 Employer-subsidized health coverage. "Employer-subsidized health coverage" means health coverage for which the employer pays at least 50 percent of the cost of coverage for the employee. "Employer-subsidized health coverage" includes employer contributions to Internal Revenue Code, section 125 plans. "Employer-subsidized health coverage" excludes dependent coverage unless the employer offers dependent coverage to employees and pays at least 50 percent of the cost of dependent coverage. Employer-subsidized health coverage for children includes coverage through either parent, including a noncustodial parent.

5.2.5 Enrollee. "Enrollee" means an individual who: 1) has been determined eligible by DHS to receive covered health services under MinnesotaCare; and 2) has paid the required premium.

5.2.6 Family. "Family" means a parent or parents and their children; or guardians and their wards who are children; grandparents, foster parents and relative caretakers[11]; and dependent siblings residing in the same household; and includes children and dependent siblings

temporarily absent from the household in settings such as schools, camps, or visitation with noncustodial parents. "Family" also means an emancipated minor and an emancipated minor's spouse.

5.2.7 Federal poverty guideline. "Federal poverty guideline" means the poverty guidelines for all states that are updated annually by the U.S. Department of Health and Human Services, as applicable to the family size involved. These guidelines are effective the July 1 following publication in the *Federal Register*.[12]

5.2.8 Other health coverage. "Other health coverage" means any of items A to H:

A. Basic hospital coverage.

B. Medical-surgical or major medical coverage.

C. Medicare Part A and/or Part B coverage under Title XVIII of the Social Security Act.

D. Supplemental Medicare coverage under MINNESOTA STATUTES, §§ 62A.31 to 62A.44.

E. Coverage through a health maintenance organization under MINNESOTA STATUTES, Chapter 62D.

F. Coverage through a health maintenance organization under MINNESOTA STATUTES, Chapter 62D, combined with Medicare benefits under Title XVIII of the Social Security Act.

G. Coverage through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) or Tricare under United States Code, title 10, Chapter 55, Sections 1079 and 1086.

H. Coverage through a community integrated service network or integrated service network under MINNESOTA STATUTES, Chapter 62N.

"Other health coverage" does not include items A to E:

A. Medical Assistance.

B. General Assistance Medical Care.

C. MinnesotaCare Health Plan.

D. Coverage under a regional demonstration project for the uninsured funded under

MINNESOTA STATUTES, §256B.73.

E. Coverage under the Hennepin County Assured Care Program.

5.2.9 Parent. "Parent" means the natural, step, or adoptive mother or father of a child.

5.3 Eligibility for MinnesotaCare

5.3.1 General Eligibility Requirements

Except as provided in sections 5.3.2, 5.3.4 and 5.3.8, an applicant or enrollee must meet the MinnesotaCare eligibility requirements in items A to J:

A. Be a resident of Minnesota in accordance with 42 CFR 435.403 for children, pregnant women, and parents and adult caretakers. The residency requirement for adults without children, for whom no FFP is claimed, is 180 days.

B. Not currently have other health coverage nor have had other health coverage during the four months immediately preceding the date coverage begins.

C. Not have current access to employer-subsidized health coverage, and employer-subsidized health coverage has not been lost due to
   (1) the employer terminating coverage during the 18 months immediately preceding the date coverage begins,[13] except that this provision does not apply to a family or individual who was enrolled in MinnesotaCare within six months or less of reapplication and who no longer has employer-subsidized coverage due to the employer terminating health care coverage as an employee benefit,[14] or
   (2) the employee failing to take up coverage offered by the employer during an open enrollment period within the preceding 18 months.

D. Identify potentially liable third-party payers and assist DHS in obtaining third party payments.

E. Have gross annual family income that does not exceed 275 percent of FPG.

F. For non-pregnant adults, not have assets that exceed the requirements in Section 5.3.5.[15]

G. Comply with the family enrollment requirements in Section 5.3.6.

H. Cooperate with the child and medical support requirements of the state Medicaid plan.

I. Not be a resident of a correctional or detention facility. [16]

J. Be a United States citizen or an immigrant who can obtain a social security number and who has permission to remain in the United States permanently.[17]

5.3.2 Exceptions to General Eligibility Requirements

Medical Assistance, general assistance medical care, and civilian health and medical program of the uniformed service, CHAMPUS, are not considered insurance or health coverage for the purposes of Section 5.3.1, item B.

5.3.3 Gross Annual Family Income

"Gross annual family income" means the total non excluded income of all family members determined in accordance with items A to E:[18]

A. The income of self-employed people is calculated in accordance with subitems (1) and (2).

(1) The adjusted gross income from the applicant or enrollee's federal income tax form for the previous year is summed with the depreciation, carryover loss, and net operating loss amounts

In the case of self-employed farmers, adjusted gross income from the applicant or enrollee's federal income tax form for the previous year is summed with the depreciation from the same tax form that applies to the business in which the family is currently engaged.[19] This provision is effective July 1, 2002.[20]

(2) If the applicant or enrollee reports that income has changed since the period of their last tax return, a percentage change is calculated by comparing this year's quarterly report with last year's quarterly report; or if the applicant or enrollee does not file quarterly reports, the applicant or enrollee must estimate the percentage increase or decrease in income. The percentage increase or decrease is applied to the amount calculated in subitem (1).

B. Earned income is calculated in accordance with subitems (1) and (2).

(1) The income of wage earners, including all wages, salaries, commissions, and other benefits received as monetary compensation from employers before any deduction, disregard, or exclusion, is calculated by determining:

(a) Income from the last 30 days.
(b) If the wage earner is employed on a seasonal basis or receives income too infrequently or irregularly to be calculated under subitem (1), total income for the past twelve months.
(c) The earned income of full-time and part-time students under age 19 is not counted as income.[21]
(d). Effective July 1, 1999 federal or state tax rebates are not counted as income or assets.

(2) When an applicant or enrollee reports that earned income has decreased from the amount calculated in subitem (1), the current amount is projected forward for 12 months.

C. Unearned income is calculated in accordance with subitems (1) and (2).

(1) The following unearned income received in the preceding tax year, with any reported changes, is projected to reflect a 12-month period:
(a) supplemental security income under title XVI of the Social Security Act;
(b) social security benefits;
(c) veterans' administration benefits;
(d) railroad retirement benefits;
(e) unemployment benefits;
(f) workers' compensation benefits;
(g) child support;
(h) spousal maintenance or support payments; and
(i) income from any other source, including interest, dividends, and rent.

(2) When an applicant or enrollee reports that unearned income has changed from the amount calculated in subitem (1), the current amount is projected forward for 12 months.

(3) Lump sums are only counted as income for people who are self-employed if claimed as income on the tax return.

D. Noncitizen applicants and enrollees whose sponsor signed an affidavit of support as defined under United States Code, Title 8, Section 1183a will be deemed to include their

sponsor's income as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, title IV, Public Law Number 104-193 in "gross family income." [22]

E. If the grandparent, relative caretaker, foster parent or legal guardian applies separately for the children, only the children's income is counted. If the grandparent, relative caretaker, foster parent or legal guardian applies with the children, the adult's income is counted in determining gross family income. [23]

5.3.4 Children in Families With Income At or Below 175 Percent of Federal Poverty Guidelines

A child who has been continuously enrolled in the Children's Health Plan (and subsequently in MinnesotaCare) or a child in a family with gross annual family income at or below 175 percent of the federal poverty guideline is eligible for MinnesotaCare to the last day of the month in which the child becomes 21 years old if the child:[24]

A. meets the requirements under Section 5.3.1, items A, E, F, and G; and

B. is not otherwise insured for the covered health services. A child is not otherwise insured for covered health services when subitems (1) or (2) or (3) apply:

(1) the child lacks coverage in two or more of the areas listed in subitems (a) to (e):
  (a) basic hospital coverage;
  (b) medical-surgical coverage;
  (c) major medical coverage;
  (d) dental coverage;
  (e) vision coverage; or
(2) coverage requires a deductible of $100 or more per person per year; or
(3) a child with a particular diagnosis lacks coverage because the child has exceeded the maximum coverage for that diagnosis or the policy of coverage excludes that diagnosis.

5.3.5 Assets

"Assets" means cash and other personal property, as well as any real property, that a family owns that has monetary value. "Net asset" means the asset's fair market value minus any encumbrances including but not limited to, liens and mortgages. Adult applicants and enrollees

who are not pregnant must meet the following asset limits:

A. A household of one person must not own more than $15,000 in total "net assets."

B. A household of two or more persons must not own more than $30,000 in total "net assets."

C. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination.

D The value of assets that are not considered in determining eligibility for medical assistance for families and children is the value of those assets excluded under the AFDC state plan as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law Number 104-193, with the following exceptions:
(1) household goods and personal effects are not considered;
(2) capital and operating assets of a trade or business up to $200,000 are not considered;
(3) one motor vehicle is excluded for each person of legal driving age who is employed or seeking employment;
(4) one burial plot and all other burial expenses equal to the supplemental security income program asset limit are not considered for each individual;
(5) court-ordered settlements up to $10,000 are not considered;
(6) individual retirement accounts and funds are not considered; and
(7) assets owned by children are not considered.[25]

Adult noncitizen applicants and enrollees who are not pregnant and whose sponsor signed an affidavit of support must count their sponsor's assets when determining eligibility.[26]

5.3.6 Family Enrollment

A. Parents who enroll in MinnesotaCare must enroll any eligible children and dependent siblings in MinnesotaCare or Medical Assistance.

B. Unless other insurance is available, children and dependent siblings may be enrolled in MinnesotaCare even if their parents do not enroll.

C. If one parent in a household enrolls in MinnesotaCare, both parents in the household must enroll in MinnesotaCare or Medical Assistance unless other insurance is available.

D. If one child in a family is enrolled in MinnesotaCare, all children in the family must be

enrolled in MinnesotaCare or Medical Assistance unless other insurance is available.

E. If one spouse in a household is enrolled in MinnesotaCare, the other spouse in the household must enroll in MinnesotaCare or Medical Assistance unless other insurance is available.

F. Except as provided in item B, families cannot enroll only some uninsured members in MinnesotaCare.

G. In families that include a grandparent, relative caretaker, foster parent or legal guardian, the grandparent, relative caretaker, foster parent or legal guardian may apply as a family or may apply separately for the children.[27]

5.3.7 Annual Redetermination Required

DHS redetermines MinnesotaCare eligibility annually for each enrollee. The 12-month period begins in the month after the month the application is approved.[28] Enrollees must provide the information needed to redetermine eligibility annually, before the anniversary date of initial eligibility.

5.3.8 Reporting Changes

Enrollees must report to DHS any changes in income.

5.3.9 Continuous Eligibility

An enrollee remains eligible for MinnesotaCare regardless of the age or the presence or absence of children in the household as long as the enrollee:

A. Maintains residency in Minnesota;

B. Has annual income that is equal to or less than 275 percent of FPG or 10 percent of their annual income is less than the annual premium for a policy with a $500 deductible through the Minnesota comprehensive health association (MCHA). Families whose income exceeds these requirements must be given an 18-month notice period prior to disenrollment;[29]

C. Meets all other eligibility criteria; and

D. Is continuously enrolled in MinnesotaCare or Medical Assistance. To be continuously enrolled, an enrollee's re-application must be received by DHS before the last day of the first calendar month following the date of notice of termination of coverage from

MinnesotaCare or Medical Assistance.

5.4 Application; Enrollment; Coverage Dates

5.4.1 Application Sources

Applicants may apply directly to DHS or through appropriate referral sources.

A. Appropriate referral sources include but are not limited to: eligible provider offices; local social service agencies; school district offices; public and private elementary schools in which 25 percent or more of the students receive free or reduced price lunches; community health offices; WIC program sites.

B. Referral sources that accept applications from applicants must send applications to DHS within five working days after receipt.

C. A family member who is age 18 or over or an authorized representative may apply on an applicant's behalf. [30]

5.4.2 Necessary Information for Eligibility Determination

Applicants must provide all information necessary to determine eligibility for MinnesotaCare and potential eligibility for Medical Assistance, including subitems A to F.

A. Social security number.
B. Household composition.
C. Availability of other health coverage, including access to employer-subsidized health coverage.
D. Gross annual family income.
E. Documentation of immigration status for applicants and enrollees who are not United States citizens.[31]
F. Any additional information needed by DHS to determine or verify eligibility.

5.4.3 Eligibility Determination Deadline

DHS determines an applicant's eligibility within 30 days after a complete application is received by DHS. Applicants who, from the information provided on the application, appear to meet all eligibility requirements are enrolled. Enrollees must provide all required verifications within 30

days of enrollment or coverage is terminated. Enrollees who are determined to be ineligible when verifications are provided are disenrolled from the program. [32]

5.4.4 Enrollment and Beginning of Coverage

A. An applicant is enrolled in MinnesotaCare on the date the following are completed:

(1) A complete application is received by DHS and the applicant is determined eligible under Section 5.3.
(2) The initial premium payment under Section 5.5 is received by DHS.

B. Coverage begins the first day of the calendar month following the date of enrollment, except:

(1) Coverage for newborns is automatic and begins immediately from the moment of birth if the mother is enrolled.[33]
(2) Coverage for eligible adoptive children of a family enrolled in MinnesotaCare begins on the date of placement for the purpose of adoption.
(3) Coverage for other new members of an enrolled family begins the first day of the month following the month in which the new member's eligibility is determined and the first premium payment is received.
(4) Coverage of enrollees who are hospitalized on the first day of the month following enrollment begins the day following the date of discharge from the hospital.

C. Coverage begins the first day of the calendar month for which the enrollee requests and pays for retroactive coverage, after meeting the following requirements:[34]

(1) Must be a former MA or GAMC enrollee.
(2) Must apply for MinnesotaCare within 30 days following termination of MA or GAMC.
(3) Must return all requested MinnesotaCare verifications within 30 days of written request for verifications.
(4) Must be eligible for ongoing MinnesotaCare.
(5) Must pay the initial MinnesotaCare premium within 30 days of the initial premium billing.
(6) Must pay the optional premium for the retroactive months within 30 days of the optional premium billing.

5.5 Premium Payments

5.5.1 Premium Payments

Applicants and enrollees must pay a premium to enroll and to continue enrollment in MinnesotaCare. The amount of premium is based on the family's gross annual family income. If a family reports increased income after enrollment, premiums are not adjusted until eligibility renewal. The amount of the premium is:

A. $4 per month for each child in a family whose income does not exceed 150 percent of FPG; plus

B. For any family member not included under Item A, the amount determined in accordance with the premium tables, included as Attachment A to this document. Premium tables are updated annually in response to changes in federal poverty guidelines.

5.5.2 Premiums Paid Monthly, Quarterly, or Annually

Applicants and enrollees may choose to pay premiums on a monthly, quarterly or annual basis and may change payment schedules at the time a premium is due.

5.5.3 Billing Notices

DHS mails premium payment billing notices as follows:

A. For monthly premiums, by the first day of the month preceding the month for which coverage will be provided.

B. For quarterly premiums, by the first day of the month preceding the first month of the quarter for which coverage will be provided.

C. For annual premiums, by the first day of the month preceding the first month of the year for which coverage will be provided.

5.5.4 Premium Payment Dates

A. An initial premium must be received by DHS within four months after the date on the applicant's first premium notice.

B. Subsequent premiums must be received by DHS as follows:

(1) monthly premiums by the 15th of the month preceding the month for which the premium is paid;
(2) quarterly premiums by the 15th of the month preceding the first month of the quarter for which the premium is paid;
(3) annual premiums by the 15th of the month preceding the first month of the year for which the premium is paid.

5.5.5 Premium Payment Options

DHS may permit enrollees to pay premiums by check, credit card, recurring automatic checking withdrawal, one-time electronic transfer of funds, wage withholding (with the consent of the employer and the employee), or using state tax refund payments.

At application or re-application an applicant or enrollee may authorize DHS to collect funds from the applicant's or enrollee's state income tax refund for premium obligations. The applicant or enrollee may also authorize the commissioner to apply for the working family tax credit on behalf of the applicant or enrollee for payment of premium obligations. [35]

5.5.6 Disenrollment

A. DHS will disenroll enrollees who fail to pay the required premium when due, unless the enrollee is pregnant or is a child under age two. A dishonored check is considered failure to pay the premium and the agency may demand a guaranteed form of payment to replace a dishonored check.[36] Nonpayment of the premium results in disenrollment from the plan effective for the calendar month for which the premium was due.[37]

B. If an enrollee who is pregnant fails to pay the premium, MinnesotaCare coverage continues to the last day of the month following the month of the 60th day post-partum.

C. If the premium is not paid for an enrollee who is a child under age two, MinnesotaCare coverage continues to the last day of the month following the month in which the child becomes two years of age.

5.5.7 Reenrollment

A. An enrollee who voluntarily terminates coverage from the program[38] or who is disenrolled for failure to pay the required premium is not eligible to reenroll until four calendar months after the date coverage terminates unless the person demonstrates good cause for voluntary termination or nonpayment and:

(1) complies with sections 5.3.1 through 5.5.7; and
(2) pays the unpaid premium for any month in which coverage was provided.

B. The four-month penalty under Item A is not applicable to individuals under Section 5.5.6, items b and c.

C. Good cause for nonpayment does not exist if a person chooses to pay other family expenses instead of the MinnesotaCare premium.

D. Good cause for nonpayment and voluntary termination means, generally, circumstances that excuse an enrollee's failure to pay the required premium when due or voluntarily terminating coverage, including circumstances such as:

(1) because of serious physical or mental incapacity or illness, the enrollee fails to pay the premium;
(2) the enrollee voluntarily disenrolls under the mistaken belief that other health coverage is available;
(3) the enrollee does not receive a regular source of income on which the enrollee has relied to pay the required premium.

E. DHS determines whether good cause exists based on the weight of the corroborative evidence submitted by the person to demonstrate good cause.

5.6 Coordination of MinnesotaCare and Medical Assistance

5.6.1 Medical Assistance Information

Information regarding Medical Assistance eligibility is provided to all applicants and enrollees.

5.6.2 Enrollee Eligibility for Medical Assistance

A. Enrollees may apply for and become eligible for Medical Assistance if they choose and if they meet the eligibility requirements for Medical Assistance.

B. MinnesotaCare premiums paid by an enrollee may be used as medical expenses to meet a spend down for Medical Assistance.

C. An enrollee who is determined eligible for Medical Assistance without a spend down and chooses to receive Medical Assistance instead of MinnesotaCare will be disenrolled from MinnesotaCare. MinnesotaCare coverage terminates the last day of the calendar month in which DHS receives notice of the enrollee's Medical Assistance eligibility.

Section Five —MinnesotaCare Eligibility

5.7 Quality Control

5.7.1 Random audits

DHS performs audits of randomly selected enrollees to verify enrollees' gross annual family income and MinnesotaCare eligibility. The health care programs application booklet includes the following statement:

> The State or Federal Quality Control Agency may randomly choose your case for review. They will review statements you have made on forms. They will check to see if we figured your eligibility correctly. The Federal Quality Control Agency will tell you about any contact they intend to make. If you do not cooperate, you may lose benefits.

Enrollees being audited must provide additional income and eligibility information, including items A to H:

A. Federal income tax returns.

B. Federal W-2 forms.

C. Employment check stubs.

D. Family composition.

E. Residency.

F. Length of time without health insurance.

G. Access to employer-subsidized coverage.

H. Any additional information necessary to determine income and eligibility.

Currently, random audits are not being performed because verification prior to enrollment or within a 30-day period is required. However, Minnesota is examining its eligibility verification process to determine if it is an unnecessary barrier to eligibility that results in people being determined ineligible for not providing verification, when they in fact meet the eligibility requirements. If the State changes its policy, we will so inform HCFA and request amendments to the operational protocol as necessary.

5.7.2 Disenrollment

DHS disenrolls enrollees who fail to provide information required under Section 5.7.1. MinnesotaCare coverage terminates the last day of the calendar month following the month in which notice of cancellation is sent. People may reenroll after complying with this section and being determined eligible for MinnesotaCare.

5.8 Appeals

DHS follows the notice and fair hearing requirements of 42 CFR, Section 431, subpart E.

Section Five —MinnesotaCare Eligibility

5.9 General Comparison of MA and MinnesotaCare Eligibility

Category or Policy	Medical Assistance	MinnesotaCare
Income Standards	**Pregnant Women** Income ≤ 275% FPG	**Pregnant Women** Income ≤ 275% FPG
	Newborns All children born to women eligible for MA at the time of the birth are automatically eligible and remain eligible for MA through the month of their *second* birthday, without regard to changes, as long as they continue to live with their mothers.[39]	**Newborns** All children born to women on MinnesotaCare and eligible at birth are automatically eligible and remain eligible for MinnesotaCare through the month of their *second* birthday, without regard to changes, as long as they continue to live with their mothers.

Category or Policy	Medical Assistance	MinnesotaCare
	Children Infants zero to 2 eligible with income ≤ 280% FPG.[40] Children 2 through 5 eligible with income ≤ 133% FPG. Children 6 and older, born on or after 10/1/83, eligible ≤ 100% FPG. Children born before 10/1/83 eligible through age 18 with income ≤ 133 1/3% AFDC (60% to 70% FPG). Children < 21 with income > these standards may spend down to 133 1/3% AFDC. Dependent children in low-income families with incomes = AFDC standards in effect on 7/16/96, as subsequently increased, and the TANF standards.	**Children** Children 0 to 21 eligible with income ≤ 275% FPG.
	Parents and Relative Caretakers Eligible to 133 1/3% of AFDC. People with income > this standard may spend down to 133 1/3% AFDC. Parents and relative caretakers in low-income families with incomes = AFDC standards in effect on 7/16/96, as subsequently increased.	**Parents and Relative Caretakers** Eligible to 275% FPG.

Section Five —MinnesotaCare Eligibility

Category or Policy	Medical Assistance	MinnesotaCare
	Adults without Children Aged, blind or disabled eligible to 133 1/3% of AFDC. Aged, blind, or disabled with income > this standard may spend down to 133 1/3% AFDC. Others eligible to 133 1/3% of AFDC for *state-funded* GAMC program.	**Adults without Children** Eligible to 175% FPG under *state-funded* MinnesotaCare program.
Insurance Barriers	No barriers. Recipients must accept cost effective insurance.	May not have had health coverage in the past four months. May not have current health coverage. May not have current access to employer-subsidized health coverage (ESI), or have had access to employer-subsidized coverage through the current employer for 18 months prior to application or re-application. May not have lost ESI in the past 18 months because an employer terminated health care coverage as an employee benefit except that this provision does not apply to a family or individual who was enrolled in MinnesotaCare within six months or less of reapplication and who no longer has employer-subsidized coverage due to the employer terminating health care coverage as an employee benefit.. Note: Children under 150% FPG are not subject to the 4-month or the 18-month barrier. They may have current health coverage if it is considered under-insured.
Income	Every 6 months if medically needy, unless household has unvarying,	

Section Five —MinnesotaCare Eligibility

Category or Policy	Medical Assistance	MinnesotaCare
Reviews	unearned income or solely excluded income. Every 12 months for categorically needy.	Every 12 months.
Income Methodologies	For families and children other than infants and pregnant women, the following disregards and deductions are applied: Earned income disregards- • $90 unlimited • $30 for 12 months • 1/3 of remainder for 4 months Dependent care deduction- · Up to $200 per child < 2 • Up to $175 per child ≥ 2 $50 disregard for child support received. Deduct court-ordered child support paid. Other disregards as required by federal law.	Use gross income. Earned income of students under age 19 is disregarded. Tax rebates are disregarded. In the case of self-employed farmers, adjusted gross income from the applicant or enrollee's federal income tax form for the previous year is summed with the depreciation from the same tax form that applies to the business in which the family is currently engaged *If income exceeds income standard at renewal, eligibility will continue, but the family must pay full premium. If 10% of the family's gross income is equal to or more than the Minnesota Comprehensive Health Association premium, the family will lose MinnesotaCare in 18 months.[41]
Assets	No asset requirement for children and pregnant women. $3,000/individual $6,000/couple $200 for each additional person	No asset requirements for children and pregnant women. For others: $15,000 for a household of one $30,000 for a household of two or more
Premiums	No premiums, but spend downs may apply to medically needy and residents of institutions.	Premiums are based on income and household size. Children in families with gross family income at or below 217 percent of federal poverty guidelines who are eligible for MinnesotaCare in the first month following termination from Medical Assistance may elect to pay no premium for 12 months, and instead be subject to copayments.

Category or Policy	Medical Assistance	MinnesotaCare
		Children under 150% FPG have a $4/month premium. Pregnant women and children under age 2 are not disenrolled for nonpayment of premiums.

Section Six —MA Covered Services

6.1 Covered Services

6.1.1 State Plan and Home- and Community-Based Services

For MA recipients, Minnesota covers the services identified in the state plan, as well as home- and community-based services identified in Minnesota's §1915(c) waivers. In addition, for all pregnant women receiving MA, Minnesota covers the same benefit set as is covered for a qualified pregnant woman defined in §1902(a)(10)(A)(I)(iii).

For information describing how covered services are purchased, see Section Eight.

6.1.2 Cost Sharing

Consistent with the state plan, Minnesota does not apply cost sharing to MA recipients beyond spend downs.

Section Six —MA Covered Services

Section Seven —MinnesotaCare Coverage

7.1 Covered Services

7.1.1 Covered Health Services for Children

For children under age 21, MinnesotaCare covers the same benefit set as the state plan authorizes for categorically needy MA recipients.

7.1.2 Covered Health Services for Adults

Pregnant Women. For pregnant women, MinnesotaCare covers the same benefit set as the state plan authorizes for qualified pregnant woman MA recipients.

Non-Pregnant Adults. For all other adults, MinnesotaCare covers the same benefit set as the state plan authorizes for categorically needy MA recipients, except that the following services are not covered:

- Inpatient hospital services over a $10,000 annual benefit limit for non-pregnant adult enrollees with gross family income that exceeds 175 percent of FPG.[42]
- Services included in an individualized education plan.
- Private duty nursing services.
- Nonpreventive dental services for non-pregnant adult enrollees with gross family income that exceeds 175 percent of FPG.
- Orthodontic services.
- Nonemergency medical transportation services.
- Personal care services.
- Targeted case management services.
- Nursing facility services.
- ICF/MR services.
- Outpatient mental health services other than diagnostic assessments, psychological testing, explanation of findings, medication management by a physician, day treatment, partial hospitalization, and individual, family, and group psychotherapy.

7.1.3 Covered Access Services

Interpreter Services. MinnesotaCare covers sign and spoken language interpreters who assist an enrollee in obtaining MinnesotaCare eligibility and covered services.

7.2 Cost-Sharing

7.2.1 Inpatient Hospital Co-Insurance

For non-pregnant adult enrollees with family income that exceeds 175 percent of FPG, MinnesotaCare applies a coinsurance of ten percent of the charges for inpatient hospital services, subject to an annual out-of-pocket maximum of $1,000 per individual and $3,000 per family.

This provision will no longer apply effective January 1, 2001.[43]

7.2.2 Prescription Drug Copayment

For non-pregnant adult enrollees, MinnesotaCare applies a copayment of $3 per prescription.

7.2.3 Eyeglass Copayment

For non-pregnant adult enrollees, MinnesotaCare applies a copayment of $25 per pair of eyeglasses.

7.2.4 Dental Copayment

For non-pregnant adult enrollees with family income equal to or less than 175 percent of FPG, MinnesotaCare applies a copayment of 50 percent of the fee-for-service MA payment rate for nonpreventive dental services.

7.2.5 Pregnant Woman Refund

Copayments totaling $30 or more, paid by a pregnant woman after the date the pregnancy is diagnosed, are refunded.

7.3 Third Party Liability

The third-party liability requirements of 42 CFR, Part 433, Subpart D apply in accordance with Minnesota's Medicaid state plan.

Cost-effective group health insurance will not be purchased by MinnesotaCare, in accordance with the option afforded the State at §1906(a) of the Social Security Act.

When the State provides, pays for, or becomes liable for covered health services, the State will have a lien for the cost of the covered health services upon any and all causes of action accruing to the enrollees, or to the enrollees' legal representatives, as a result of the occurrence that necessitated the payment for the covered health services.

Section Seven —MinnesotaCare Coverage

Section Eight —MA Purchasing and Service Delivery

8.1 MA Purchasing

Except as provided for in Section 8.2, Minnesota purchases services for MA recipients in accordance with the state plan and §1915(b) and §1915(c) waivers. Currently, this includes:

- Fee-for-service purchase of services under the state plan.
- Comprehensive, risk-based managed care, authorized under §1915(a) of the Social Security Act, for dually eligible Medicare and Medicaid recipients who voluntarily enroll with an MCO for Medicare and Medicaid coverage.[44] This purchasing model includes both acute and certain long term care services.
- Consolidated Chemical Dependency Treatment Fund §1915(b) waiver for non-PMAP enrollees.
- §1915(c) waivers for people at risk of requiring institutional care.

8.2 PMAP

8.2.1 PMAP Generally

PMAP is a prepaid, capitated managed care service delivery mechanism that is currently operating in sixty of Minnesota's eighty-seven counties. Participating MA recipients in PMAP counties are required to choose a participating health plan and then receive all health care services (except home- and community-based waiver services, nursing facility services (NF) beyond 90 days, intermediate care facility services for people with mental retardation (ICF/MR), abortion services; targeted case management services; and residential rehabilitative services for children with severe emotional disturbance) including coverage of Medicare copayments and deductibles through the health plan.

Managed care is an organized and coordinated health care system that includes preestablished provider networks and payment arrangements; administrative and clinical systems for utilization review, quality improvement, patient and provider services; and comprehensive or targeted management of health services.

Chart 1 in Section 2.2.1 includes information on the expansion of PMAP throughout most of the State. By the end of 2001, the State intends to implement either PMAP or county-based purchasing in the remaining counties.

8.2.2 Populations Enrolled in PMAP

Section Eight —MA Purchasing and Service Delivery

Most Aid to Families with Dependent Children (AFDC), needy children, pregnant women, and aged MA recipients, in addition to blind or disabled people in Itasca County, are mandated to participate in PMAP in the counties where PMAP is operating,[45] with the following exceptions:

Excluded Groups

A. Persons eligible for Medical Assistance due to blindness or disability as determined by the Social Security Administration or the state medical review team, unless:
   (i) they are 65 years of age or older, or
   (ii) they reside in Itasca County or they reside in a county in which the commissioner has authority to conduct a pilot project under another §1115 waiver.

B. Recipients who currently have private coverage through a health maintenance organization. These recipients may voluntarily enroll if their private coverage is through a health plan that is a PMAP provider.

C. Recipients who are eligible for medical assistance by spending down excess income for medical expenses other than the nursing facility per diem expense.

D. Recipients who receive benefits under the Refugee Assistance Program and have no other basis of MA eligibility.

E. Recipients residing in state institutions.

F. Recipients who are terminally ill and who, prior to enrollment in a health plan, are being treated by a primary physician who is not part of a health plan network.

G. Recipients who have a communicable disease with a prognosis of terminal illness and who, prior to enrollment in a health plan, have a nonparticipating primary physician who certifies that disruption of the existing patient-physician relationship is likely to affect the patient's compliance with health services. In this instance, "terminal illness" may exceed six months.

H. Individuals who are Qualified Medicare Beneficiaries (QMBs), who are not otherwise receiving MA.

I. Individuals who are Service Limited Medicare Beneficiaries (SLMB) and who are not otherwise receiving MA.

J. Non-documented alien recipients who only receive emergency MA under Minnesota Statutes, Section 256B.06, Subdivision 4 or emergency GAMC under Minnesota Statutes, Section 256D.03, Subdivision (3).

Voluntary Groups

Members of these eligibility groups may enroll in PMAP on a voluntary basis.

A. Children who are SED and receiving case management services.

B. Adults who are SPMI and receiving case management services.

Section Eight —MA Purchasing and Service Delivery

8.2.3 PMAP Coverage

Services covered under PMAP are state plan services, including Medicare copayments and deductibles for recipients dually eligible for MA and Medicare, with the following differences:

Nursing Facility and Skilled Nursing Facility Services

For any recipient who is age 65 or older, is non-institutionalized and is currently enrolled or enrolls in the MCO's MA product while in a community setting, MCOs will have financial responsibility for nursing facility services for 90 days. The 90 days begin at the time of the enrollee's date of admission to a skilled nursing facility (SNF) or nursing facility (NF). Any day on which a recipient is covered by MA, Medicare, or both will count as one day toward the 90-day liability period. The 90 days will be counted cumulatively until each 90th day is reached (i.e., need not be consecutive.). The MCO will be responsible for paying any coinsurance for Medicare covered days during the 90-day liability period. The 90-day liability period may be applied to an individual more than once if the requirements of the 180-day separation period are met.

Pre-admission Screening. The MCO must determine the enrollee's risk of NF admission or current need for NF care to ensure that each enrollee eligible to receive NF benefits is screened in accordance with Minnesota Statutes, Section 256B.0911. The MCOs may choose either to delegate all pre-admission responsibilities to a county or may work in cooperation with a county to carry out their pre-admission screening responsibilities. All other pre-admission screening functions remain the responsibility of the county.

The MCO may delegate pre-admission screening responsibilities to a county. If the MCO chooses to delegate these responsibilities to a county, it must abide by all level of care determinations made by that county. MCOs are required to provide care management services that are designed to ensure access to and to integrate the delivery of preventive, primary, acute, post acute, rehabilitation, and long term care services, including Elderly Waiver services, to MSHO enrollees. The care management system must be designed to ensure communication and coordination of an enrollee's care across network provider types and settings and to ensure smooth transitions for enrollees who move among various settings in which care may be provided over time. The care management system must incorporate a method for coordinating the medical needs of an individual with his or her social service needs, including coordination with social service staff and other community resources such as Area Agencies on Aging. Coordination with local agency social service staff is required when an enrollee is in need of the following services: pre-petition screening, PASARR, spousal impoverishment assessments, adult foster care, group residential housing room and board payments, extended care or halfway house services covered by the Consolidated Chemical Dependency Treatment Fund, or court-ordered treatment. The MCO must coordinate with county human service agencies for assessment and evaluation related to judicial proceedings.

The MCO may work in cooperation with a county to carry out pre-admission screening responsibilities. If the MCO chooses to work in cooperation with a county, it must conduct the pre-admission screening process as follows:

1. The MCO must conduct screenings for hospital discharges and emergency placements using the most current pre-admission screening (PAS) process and convey any information obtained during the screenings to the county.

2. The MCO must conduct OBRA Level 1 screenings and convey any information obtained during the screenings to the county.

3. The MCO must allow the county to conduct OBRA Level II evaluations when indicated, provide the nursing facility with documentation of the OBRA Level II evaluations, enter long term care screening document information, and generate Quality Assurance and Review or case mix forms.

4. For enrollees living in the community and entering a nursing facility, the MCO must conduct an in-person, pre-admission screening using the most current PAS tool and level of care criteria.

5. The MCO must notify the State of those counties where it intends to be involved in the PAS process no later than thirty days after the State has given the MCO notice of federal approval to implement this coverage.

After the 90-day liability period is expended, the State will assume responsibility for MA nursing facility days during any 180-day separation period.

PMAP Enrollees who are eligible for Medicare Part A will receive coverage for Medicare SNF days paid for either on a fee-for-service basis or through a Medicare + Choice contractor according to Medicare SNF coverage criteria.

180-Day Separation Period. If the MCO has not previously had NF liability for an enrollee, the 180-day separation period is defined as 180 consecutive days during which an enrollee mainly resides in the community after the MCO has paid for 90 days of nursing facility services. The MCO does not have responsibility for nursing facility services during this separation period.

If an enrollee is hospitalized or placed in a nursing facility for 30 days or less during the 180-day separation period, the enrollee will still be considered as continuously residing in the community, and these days will count in calculating the 180-day separation period.

If the enrollee spends more than 30 days in a hospital or nursing facility, the calculation of the 180-day separation period will begin anew when the enrollee returns to the community.

In either case, after the separation period has expired, the MCO is liable for a new, distinct 90-day SNF/NF liability period for any enrollee who is community-based on the last day of the separation period. The new liability span will begin on the first day of the next available month following the 180th day of the separation period.

Child and Teen Checkup

MCOs will provide or arrange to provide Child and Teen Checkup (C&TC) screenings to each enrollee under age 21. The following C&TC components are currently required and must be performed in accordance with C&TC program standards and according to the periodicity schedule as specified in the C&TC Chapter of the Provider Manual:

A. Assessment of physical growth.
B. Vision screening.
C. Hearing screening.
D. Health history.
E. Developmental and behavioral assessment.
F. Physical examination.
G. Nutritional assessment.
H. Immunization and review.
I. Laboratory tests.
J. Health education and anticipatory guidance.
K. An initial examination by a dentist for each enrollee beginning at age three.

Prescriptions Drugs and Over-the-Counter Drugs

Includes prescription and over-the-counter drugs prescribed by a provider who is licensed to prescribe drugs and dispensed by a provider who is licensed to dispense drugs, and that are contained in the MA Drug Formulary or are the therapeutic equivalent to MA formulary drugs.

If the prescription indicates "brand necessary" or to dispense as written (DAW), the MCO must provide the drug as written, even if there is a generically equivalent drug and even if the drug has a therapeutic equivalent in the MCO's formulary. If the MCO chooses to have a drug formulary or policies that are more restrictive than the State's, the MCO must provide any necessary drug, at its own cost, to enrollees on behalf of whom the State intervenes. If the State intervenes, the State will also initiate a corrective action plan, which the MCO must implement.

Upon the request of the State the MCO must submit a copy of its drug formulary. The MCO must notify the State of any changes to its formulary within 30 days of implementing the change.

Mental Health Services

In approving and providing mental health services, the MCO must use a definition of medical necessity that is no more restrictive than that found in Minnesota Statutes:

> "Medically necessary care" means health care services appropriate, in terms of type, frequency, level, setting, and duration, to the enrollee's diagnosis or condition, and diagnostic testing and preventive services. Medically necessary care must be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue and must:
>
> (1) help restore or maintain the enrollee's health; or
>
> (2) prevent deterioration of the enrollee's condition.

Mental health services must be provided in accordance with Minnesota Rules, and should be directed at rehabilitation of the client in the least restrictive clinically appropriate setting. The MCO must ensure that the following services are available to its enrollees:

A. Diagnostic assessment, psychological testing, and explanation of findings to establish or rule out the appropriate MI diagnosis and develop the individual treatment plan. A psychiatric assessment must include the direct assessment of the enrollee.
B. Crisis intervention (phone and walk-in).
C. Day treatment, partial hospitalization, and in-home family based mental health services.
D. Individual, family, and group therapy and multiple family group psychotherapy, including counseling related to adjustment to physical disabilities or chronic illness.
E. Inpatient and outpatient treatment.
F. Assessment of enrollees whose health care seeking behavior or mental functioning suggests underlying mental health problems.
G. Neuropsychological assessment.
H. Neuropsychological rehabilitation and/or cognitive remediation training for enrollees with a diagnosed neurological disorder who can benefit from cognitive rehabilitation services.
I. Medication management.
J. Therapeutic support of foster care.
K. Family community support services.
L. Mental health professional services required to establish or sustain the enrollee at a level of mental health functioning appropriate to the enrollee's developmental level.

MCOs must actively identify enrollees in need of mental health and chemical dependency services. An MCO must submit an annual written report describing the approaches used to comply with this requirement.

Section Eight —MA Purchasing and Service Delivery

Care Management Services

MCOs are responsible for the care management of all enrollees. The MCO's care management system must be designed to coordinate the provision of services to its enrollees and must promote and assure service accessibility, attention to individual needs, continuity of care, comprehensive and coordinated service delivery, the provision of culturally appropriate care and fiscal and professional accountability. At a minimum, the MCO's care management system must incorporate the following elements.

A. Procedures for providing and implementing individual needs assessments or diagnostic assessments, developing individual treatment plans as necessary, establishing treatment objectives, monitoring outcomes, and ensuring that treatment plans are revised as necessary. These procedures must be designed to accommodate the specific cultural and linguistic needs of the MCO's enrollees.

B. A strategy to ensure that all enrollees or authorized family members or guardians are involved in treatment planning and consent to the medical treatment.

C. A method for coordinating the medical needs of enrollee with their social service needs. Coordination with county social service staff will be required when the enrollee is in need of the following services: case management for adults with serious and persistent mental illness or children with serious emotional disturbance; prepetition screening, preadmission screening or Elderly Waiver services; extended care or halfway house services covered by the Consolidated Chemical Dependency Treatment Fund; child protection; court ordered treatment; developmental disabilities services; assessment of medical barriers to employment; or a State medical review team or social security disability determination.

D. Procedures and criteria for making referrals to specialists and subspecialists.

E. Procedures for insuring that MCO providers interact with the appropriate education personnel and participate in developing individualized education plans (IEPs) or individualized family service plans (IFSPs) for school age enrollees. If MCO-Covered services in the IEP or IFSP are provided outside of the child's education site, the MCO will provide transportation.

F. For MinnesotaCare enrollees who are hospitalized, the MCO’s responsibility for certifying the inpatient admission must include a medical necessity review of the entire confinement, not just the portion covered by the MCO.

G. Procedures for coordinating care for American Indian enrollees.

H. Procedures for coordinating with school-based health and mental health and IEP IFSP services and supports.

I. Procedures for coordinating with care coordination and services provided by children’s mental health collaboratives and family services collaboratives.

Interpreter Services

MCOs will provide sign and spoken language interpreter services that assist enrollees in obtaining their program's covered health services, to the extent that interpreter services are available to the MCO or its subcontractor when services are delivered. The MCO should not delay the delivery of a necessary health care service even if no interpreter is available. This does not relieve the MCO from using all diligent efforts to make interpreter services available. The MCO is not required to provide an interpreter for activities of daily living in residential facilities, but is responsible for providing an interpreter for medical services provided in institutional facilities.

8.2.4 Out of Network and Transition Services

Services included in the capitation, but which may be delivered out of plan

Services Received at Indian Health Service and Tribal Providers. American Indian PMAP enrollees -- living on or off a reservation -- must have direct access to services provided at Indian Health Service (IHS) facilities and 638 facilities operated by a tribe or tribal organization, even if such facilities are not participating providers. The MCO must not require any prior approval or impose any condition for an American Indian to access services at such facilities.

Family Planning Services. MCOs must comply with the sterilization consent procedures required by the federal government and must ensure free choice of family planning services. The MCO may not restrict the choice of an enrollee as to where the enrollee receives the following services:

- voluntary planning of the conception and bearing of children (Abortion is not a family planning service.);
- diagnosis of infertility, including counseling and services related to the diagnosis;
- testing and treatment of a sexually-transmitted disease; and
- testing for AIDS and other HIV-related conditions.

The MCO may require family planning agencies and other providers to refer patients back to the MCO under the following circumstances for other services, diagnosis, treatment and follow-up:

- abnormal pap smear/colposcopy;
- infertility treatment;
- non-family planning services;
- genetic testing; and
- HIV treatment.

Medical Emergency, Post Stabilization Care, and Urgent Care Services. Medical emergency, post stabilization care, and urgent care services must be available 24 hours

per day, seven days per week, and must include a 24-hour per day number for enrollees to call in case of a medical emergency. The MCO may not require prior authorization as a condition of providing a medical emergency services, and may not require an enrollee to receive a medical emergency or post stabilization care service within the MCO's network.

Out of Network Services

In addition to IHS/638 services and family planning services, MCOs must cover medically necessary out of plan or out of area services received by an enrollee in the following circumstances:

A. The enrollee requires medical emergency services.

B. The enrollee requires post stabilization care services, and (I) the MCO prior authorized the services; (ii) the MCO did not prior authorize the services because it did not respond to the request by the provider of post stabilization care services for prior authorization within one hour of receiving the request; or (iii) the MCO could not be contacted to prior authorize services. Coverage will extend until the MCO has contacted the provider of post stabilization care to arrange a discharge or transfer.

C. The enrollee is out of area and requires urgent care.

D. The enrollee is out of area and in need of non emergency medical services that are or have been prescribed, recommended or are currently being provided by a participating provider. The MCO may require prior authorization.

E. The enrollee moves out of area and this change is entered on MMIS after the cut off date, and a payment has been or will be made to the MCO for coverage for the enrollee for that same or the next month. The MCO must reimburse at no less than the MA fee-for-service rate any services provided by nonparticipating providers to the enrollee during the balance of the month or the month after which the enrollee has moved. The MCO may condition reimbursement of these out of plan services on the enrollee's requesting MCO approval or prior authorization to receive such services except for services needed to respond to a medical emergency.

F. The enrollee receives pregnancy-related services in connection with an abortion.

G. A medical service eligible for coverage has been ordered by a participating physician or dentist for an enrollee residing in a nursing facility. The MCO is responsible for providing the service and covering the cost of the service required

by the physician's or dentist's order.

Transition Services

MCOs must provide enrollees medically necessary covered services that an out of plan provider, another MCO, or the State had authorized before enrollment in the MCO. The MCO may require the enrollee to receive the services from a MCO provider, if such a transfer would not create undue hardship on the enrollee and is clinically appropriate. Transition services relating to orthodontia, mental health, at-risk pregnancy, and chemical dependency services are covered as described in the following paragraphs.

Orthodontia Care. MCOs must provide, for MA or MinnesotaCare/MA enrollees, orthodontia care if (i) an out of plan provider or the State has prior authorized such care, (ii) the care falls under an established plan of care, and (iii) the care plan has an end date. Payment to the prior provider must be at least equivalent to the State MA fee-for-service rate for orthodontia care. The MCO may transfer the enrollee to a MCO provider, if such a transfer would not create undue hardship on the enrollee, and is clinically appropriate.

At Risk Pregnancy. When a recipient enrolls in the MCO while in her third trimester of pregnancy, and her nonparticipating physician has reported her pregnancy as at-risk on the State prenatal risk assessment form, the MCO must authorize the care by nonparticipating providers for services related to prenatal care and delivery, including inpatient hospital costs for the mother and child. The MCO need not authorize payment for services by a nonparticipating provider if the nonparticipating provider does not accept from the MCO the MA rate that would be paid if the enrollee was not enrolled in the MCO. As a condition of payment, the MCO must require the nonparticipating provider to agree in writing to refrain from billing the recipient for any portion of the cost of the authorized service. The MCO may not offer a nonparticipating provider less than the comparable MA fee-for-service payment. The MCO is not responsible for additional out-of-plan care for the mother and child after discharge from the hospital.

CD Services. Services that have been authorized by the Consolidated Chemical Dependency Treatment Fund (CCDTF) prior to the recipient's enrollment in PMAP will continue to be reimbursed by the CCDTF through the duration of the period authorized. After the authorization period expires, the MCO will be responsible for providing all medically necessary services. For enrollees who are in an inpatient hospital or a Rule 35 facility (i.e., extended care, halfway house or freestanding residential CD treatment facility [IMD]) at the time of enrollment in the MCO, the effective date of the enrollment will be delayed until the month following the enrollee's discharge from the CD facility.

Mental Health Services. For any individual or family who is receiving ongoing mental health services, the MCO must, at the time of initial enrollment in PMAP, consider the

individual enrollee's prior use of mental health services, develop a transitional plan to assist the enrollee in changing mental health providers if necessary, and develop a plan to assure continuity of care.

The MCO must also develop a transitional plan for children who have previously been excluded from PMAP because they have been involved in the child protection system, placed in foster care, or diagnosed as severely emotionally disturbed. While excluded from PMAP, a treatment regimen may be initiated for those children who are assessed as having behavioral or other mental health problems. However, because the duration of the exclusion from PMAP will vary from one child to the next, some of these children may be enrolled in the MCO before their treatment program is completed. As part of the transition plan, the MCO should have a process to assure proper communication and coordination between the county social services agency and the MCO regarding the specific needs of each child.

Pharmacy. MCOs must continue authorization of all prescription drugs an enrollee is taking upon enrollment into the MCO until a transition plan can be established by the MCO.

Enrollee change of major program. MCOs must notify any affected enrollees of their right to choose to remain with their original participating providers when the enrollee was enrolled with the MCO in the same county, but under a different major program, the MCO products do not have the same participating providers; and the enrollee chooses to receive services from the participating providers from the prior enrollment with the MCO.

Services covered, but not included in capitation

The following are covered services paid for by the state on a fee-for-service basis:

- Services during retroactive eligibility
- Services in initial month of eligibility
- Abortion services
- Home- and community-based waiver services
- Nursing facility services beyond the first 90 days
- ICF\MR services
- Targeted case management services
- Residential rehabilitative services for children with severe emotional disturbance

Services for Minority and Special Needs Populations

MCOs must offer appropriate services for the following special needs groups. Services must be available within the MCO or through contractual arrangements with providers to the extent that

the service is a covered service.

Seriously and Persistently Mentally Ill (SPMI) Ongoing medications review and monitoring, day treatment, and other alternatives to conventional therapy, and coordination with the individual's case manager to assure appropriate utilization of all needed psychosocial services.

Elderly, Physically Handicapped, and Chronically Ill In-home services, neurological assessments.

Abused Children and Adults, Abusive Individuals Comprehensive assessment and diagnostic services and specialized treatment techniques for victims and perpetrators of maltreatment (physical, sexual, emotional).

Enrollees With Language Barriers Interpreter services, bilingual staff, culturally appropriate assessment and treatment. MCOs must comply with the recommendations of the Policy Guidelines published on August 30, 2000 by the Office for Civil Rights of the Department of Health and Human Services, titled "Title VI of the Civil Rights Act of 1964; Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency," by performing an assessment, developing and implementing a comprehensive written policy on language access, training staff, and monitoring performance of these obligations.

MCOs must have available bilingual material, including marketing, enrollment, and member handbooks, and provide it to single-language minority households, if the MCO determines that approximately five percent or more of those low-income households in the service area are of a single-language minority, using the most recent year of Census Bureau data available. *Single-language minority households* means households whose members speak the same non-English language and that do not include an adult fluent in English as a second language. If a client speaks a language that does not meet the five percent threshold, the MCO must assure that the enrollee receives information in his or her primary language, by providing interpreters or through other appropriate means.

By April 1, 2001, all material sent by MCOs to enrollees or recipients, that targets enrollees or recipients, must include a language block, printed in the languages required by Minnesota Statutes, Section 256B.69, Subd. 27, and in Arabic, that informs the enrollee or recipient that the document contains important information, and directs him or her to call the MCO to have the document translated.

When an individual is enrolled in PMAP, the enrollment form will indicate whether the enrollee needs the services of an interpreter and what language she or he speaks. Upon receipt of enrollment information indicating interpreter services are needed, the MCO

must contact the enrollee by phone or mail in the appropriate language to inform the enrollee how to obtain primary care services. In addition, whenever an enrollee requests an interpreter in order to obtain health care services, the MCO must provide the enrollee with access to an interpreter.

Cultural and Racial Minorities Culturally appropriate services rendered by providers with special expertise in the delivery of health care services to the various cultural and racial minority groups.

Dual MI/Developmentally Disabled (DD) or MI/CD clients Comprehensive assessment, diagnostic and treatment services provided by staff who are trained to work with clients with multiple disabilities and complex needs.

Lesbians and Gay Men Sensitivity to critical social and family issues unique to lesbians and gay men.

Hearing-Impaired Access to TDD and hearing-impaired interpreter services.

Enrollees in Need of Gender Specific Mental Health and/or Chemical Dependency Treatment MCOs must provide their enrollees with opportunities to receive mental health and/or chemical dependency services from the same sex therapist and the option of participating in an all male or all female group therapy program.

Children and Adolescents, Including Severely Emotionally Disturbed (SED) Children and Children Involved in the Child Protection System Services specific to the needs of these groups, including day treatment, home-based mental health services, and inpatient services. The services must be provided in the least restrictive clinical setting, individualized to meet the specific needs of each child, and designed to provide early identification and treatment of mental illness. The MCO must coordinate services with the child's county case manager(s).

Developmentally Disabled (DD) Specialized mental health and rehabilitative services and other appropriate services covered by MA. Such services may include: family planning services adapted to the special needs of the developmentally disabled population, behavior management, rehabilitative and therapeutic services, pain management, or genetic counseling. After an initial assessment, a written treatment plan must be developed for the enrollee when appropriate. As required, the treatment plans should provide access to a coordinated outpatient rehabilitation team, independent living skills training, and services designed to maintain or increase function and prevent further deterioration or dependency. The treatment plan should be coordinated with available community resources and support systems, including the enrollee's county DD case manager. The treatment plan must identify the people responsible for providing services

and a case manager. For enrollees with multiple handicaps, a multi-disciplinary provider consultation should be arranged. Although continuity of care should be a major consideration in the treatment planning process, referrals to specialists and sub-specialists must be made when medically indicated.

Visually Impaired All membership materials must include the following statement: "This information is available in other forms to people with disabilities by calling 000-000-0000 (voice), toll free at 1-800-000-0000, or 000-000-0000 (TTY)."

American Indians Culturally appropriate services rendered by providers with special expertise in the delivery of health care services to the various tribes.

A. Out-of-network services. DHS has consulted with tribal governments to develop an approach to MA purchasing for American Indian recipients that is different from the remainder of the MA program, in order to address issues related to tribal sovereignty, the application of federal provisions that prevent Indian Health Services (IHS) facilities from entering into contracts with MCOs, and other issues that have posed obstacles to enrolling American Indian/Alaska Native MA recipients living on reservations into PMAP.

American Indian MA recipients will be required to participate in PMAP and, whether residing on or off a reservation, will have direct access out-of-network services at IHS or 93-638 facilities. DHS will purchase these out-of-network services on a FFS basis using payment rates negotiated between IHS and HCFA, except where a 93-638 facility elects to receive the MA rate applicable to non-tribal providers.

B. Marketing, education, and enrollment. The State will consult with tribal governments before approving marketing materials that target American Indian recipients. Certificates of Coverage will include a description of how American Indian enrollees may directly access IHS and 93-638 providers, and how they may obtain referral services. The State will consult with tribal governments prior to approving the COC.

MCOs will provide training and orientation materials to Tribal governments upon request, and make training and orientation available to interested Tribal governments. Tribal governments may assist the State in presenting or developing materials describing various MCO options to their members. If a Tribal government revises any MCO materials, the MCO may review them. No MCO materials will be distributed until there is agreement between the MCO and Tribal government on any revisions.

C. Access. The MCO may not require any prior approval or impose any condition for an American Indian to access services at IHS or 93-638 facilities. A physician in an IHS or 93-638 facility may refer an American Indian recipient to an MCO participating provider for services covered by MA, and the MCO may not require the recipient to see a primary care provider within the MCO's network prior to the referral. The participating provider may determine that services are not medically necessary.

8.2.5 Alternative Services; Additional Services; Limitations on Services

Alternative Services Permitted

To the extent consistent with Minnesota Statutes, MCOs may, at their discretion, pay for or provide alternative health services if they are, in the judgement of the MCO, medically appropriate and cost-effective. The provision of alternative services will not affect the calculation of capitation rates.

Additional Services Permitted

MCOs may provide or arrange to have provided services in addition to the services covered under the state plan for enrollees for whom, in the judgment of the MCO, the provision of such services is medically necessary. The provision of any such services will not affect the calculation of capitation rates.

Limitations on MCO Services

A. Medical Necessity. Unless otherwise provided in contract, MCOs are responsible for the provision and cost of the health care services only when they are deemed to be medically necessary by the MCO.

B. Coverage Limited to Program Coverage. Except as otherwise provided by contract, all health care services prescribed or recommended by a participating physician, dentist, care manager, or other practitioner, or approved by the MCO, are limited to services that are covered under MA or MinnesotaCare.

C. Nursing Facility Per Diem Services. Nursing facility per diem services that are not a covered service described above or authorized by a MCO are not a covered service.

D. ICF/MR Services. ICF/MR services are not a covered service.

E. Special Education Services. MCOs may not deny the provision of or payment for medical services for which the MCO is otherwise responsible, solely because those services are included in a child's individualized education program, or an infant's or

toddler's individualized family service plan. The MCO must pay for the cost of transporting a child to another site if the MCO does not provide services at the child's education site.

8.2.6 Services Not Included in Capitation

Although MCOs may provide the following services, the prepaid capitation rate does not include payment for the following services, and therefore MCOs are not required to provide them.

A. **Federal and State Institutions.** All claims arising from services provided by institutions operated or owned by the federal government, a State regional treatment center, a state-owned long term care facility, or an institution for mental disease (IMD) unless the services are approved by the MCO.

B. **Cosmetic Procedures or Treatment.** Cosmetic procedures or treatment are not covered, except that the following services are not considered cosmetic and therefore must be covered: services necessary as the result of injury, illness or disease, or for the treatment or repair of birth anomalies.

C. **Incidental Services.** Incidental services are not covered, including but not limited to rental of television or telephone, barber and beauty services, and guest services that are not Medically Necessary.

D. **Mental Health Case Management.** Mental health case management services for persons with serious and persistent mental illness, according to Minnesota Rules, Parts 9520.0900 to 9520.0926, and mental health case management for Children with severe emotional disturbances according to Minnesota Rules, Part 9505.0322 are not covered.

E. **Waivered Services.** Waivered services provided under home-based and community-based waivers authorized under 42 U.S.C., Section 1396 are not covered.

F. **Fertility Drugs and Procedures.** Fertility Drugs are not covered when specifically used to enhance fertility. The following procedures also are not covered: in vitro fertilization, artificial insemination, and reversal of a voluntary sterilization.

G. **Gender Reassignment Surgery.** Gender reassignment surgery and other gender reassignment medical procedures including drug therapy are not covered unless the enrollee began receiving such services prior to July 1, 1998. Such services are not covered for PGAMC Enrollees unless the Enrollee began receiving them prior to July 1, 1995.

H. **IEP and IFSP Services**. Medically Necessary MA services that would otherwise be

covered by this contract, identified in an Enrollee's Individual Education Plan (IEP) or Individual Family Service Plan (IFSP) and provided by school districts are not covered.

I. **Dental Services.** Dental services are not covered for enrollees whose county of residence is Cass, Crow Wing, Morrison, Todd, or Wadena for calendar year 2001, nor in 2002 unless the State gives 180 days notice of their inclusion.

J. **Experimental or Investigative Services.**

K. **Rule 5 Facility Services.**[46] Enrollees may obtain Rule 5 facility services from a local agency. The MCO remains responsible for other medical costs while the child resides in the Rule 5 facility and remains in managed care.

L. **Other.** All other exclusions set forth in Minnesota Statutes, Section 256B.0625, Minnesota Statutes, Section 256B.69, Minnesota Rules, Part 9505.0170 to 9505.0475, and Minnesota Rules, Part 9500.1450 to 9500.1464 are not covered.

8.2.7 Time Frame to Evaluate Requests for Services.

General Request for Services MCOs must evaluate all requests for services within 30 working days of receipt of all required information. The MCO must communicate its decision on all requests for services to the enrollee or his or her authorized representative and the appropriate provider within three working days after a decision is made

Request for Urgent Services If the need for services is urgent or required to prevent institutionalization, the MCO must evaluate the request for services and communicate its decision to the enrollee or authorized representative and the provider within an expedited time frame appropriate to the type of service and the need for service that has been requested by the enrollee or on the enrollee's behalf.

Request for Mental Health or Chemical Dependency Services The MCO must provide mental health and chemical dependency services in a timely manner. Enrollees who require chemical dependency or mental health crisis intervention services should be seen immediately. Other enrollees in need of mental health and chemical dependency services should have an appropriate assessment performed within two weeks.

8.2.8 Access to Culturally and Linguistically Competent Providers

Provider Pool. To the extent possible, MCOs must provide enrollees with access to providers who are competent in the language and culture of the enrollee, including enrollees who are deaf. MCOs are required to work toward increasing the pool of culturally and linguistically competent providers where there is an identified need,

including participating in the State's needs assessment process and efforts to increase the pool.

Needs Assessment. MCOs must perform a cultural competence community needs assessment regarding enrollees, using a tool mutually agreed upon by the State and the MCO. MCOs are required to submit a written report detailing findings of the assessment. MCOs must submit, by December 31, 2002, a cultural competence plan.

8.2.9 Carve Outs

Dental Services Currently, the State is developing a dental carve-out project to improve access in Cass, Crow Wing, Morrison, Todd, and Wadena counties, a region of the state that experiences continuing poor access to dental care. The State will apply for a State Plan Amendment to alter its payment rate for dental providers in these counties. The State is maintaining existing PMAP and Prepaid MinnesotaCare contracts with the MCOs, but has carved out the dental benefit.[47]

The State also continues to explore other strategies to improve dental access in certain areas of the state. The State will keep HCFA apprized of any new projects as they are developed.

Medical education and research costs (MERC) MA payments for the costs of medical education are removed from the capitation payments to the MCOs under PMAP and directed to a medical education trust fund for direct distribution to teaching entities. The State has established this medical education and research trust fund through the Minnesota Department of Health.

Approximately 4.18 percent of the MA capitation rate is derived from historical medical education payments under FFS. In addition:

- Effective July 1, 2001, the PMAP rates were increased by $5.074 million per year;
- Beginning July 1, 2002, PMAP rates are increased by additional $12.7 million per year; and
- Beginning July 1, 2003, PMAP rates are increased by additional $4.7 million per year.

These transfers are contingent on federal approval. These amounts are also carved out and transferred to the trust fund.

Payments from the trust fund for medical education are determined according to a distribution formula developed through recommendations from a medical education and

research committee of health care professionals and institutions.

The initial trust fund amounts (4.18 percent of MA capitation) are distributed according to a formula based on two factors:

1. An education factor determined by the number of eligible trainees and statewide average costs per trainee, by type of trainee, in each program.

2. A public program factor determined by the total volume of public program revenue (MA, GAMC, PMAP, and PGAMC) received by each training site as a percentage of all public program revenue received by all training sites in the trust fund pool.

Each factor is weighted equally. Training sites that receive no public program revenue are ineligible for payments from the PMAP funding transferred to the trust fund. The carve out of MERC funds will be implemented in the seven metropolitan counties (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington counties) in 2001, and in the rest of the State in 2002.

The additional $5.074 million per year is distributed as follows:

- Fifty percent is to be distributed to the University of Minnesota Board of Regents, to be used for the education and training of primary care physicians in rural areas, and efforts to increase the number of medical school graduates choosing careers in primary care.

- Twenty-four percent is to be distributed to the Hennepin County Medical Center for graduate clinical medical education.

- Twenty-six percent is to be used to fund grants to teaching institutions and clinical training sites for projects that increase dental access for under served populations and promote innovative clinical training of dental professionals.

The additional $12.7 million available after July 1, 2002 and $4.7 million after July 1, 2003 will be distributed to the University of Minnesota Academic Health Center for use in clinical graduate medical education.

8.2.10 PMAP Marketing

Marketing

Except through mailings and publications, as described below, MCOs and their subcontractors, agents, independent contractors, employees, and providers are restricted from marketing and promotion to recipients who are not their enrollees. The prohibition includes telephone marketing, face-to-face marketing, promotion, cold-calling, and direct mail marketing. Permissible mailings must not contain false, inaccurate, or materially misleading information.

Mailings to Recipients. The MCO may make no more than two mailings per contract year to all MA and MinnesotaCare recipients who are, or are eligible to become, enrollees of a MCO under contract with the State and who reside in the service area. The mailings must be made at MCO expense, using a mailing list provided by the State. All mailings must be sent to all recipients within a specified, State-approved region, who are in the same program, and who are enrollees, or eligible to become enrollees, of a MCO in the service area receiving the mailing.

Prior Approval of Materials. MCOs are required to present to the State for approval all marketing materials that the MCO or its subcontractors plan to disseminate during the contract period, and that are targeted to public program recipients or potential recipients, prior to the MCO's use of such information and materials. Such materials may include, but are not limited to, posters, brochures, internet web sites, billboards, bus ads, audio scripts, text of sales presentations, material containing statements about the benefit package, and provider network-related materials. If the marketing materials target American Indian recipients, the State will consult with tribal governments within a reasonable period of time before approval.

Inducements to Enroll. MCOs, their agents, and their marketing representatives may not offer any rewards, favors, or compensation as inducements to recipients to enroll in the MCO. Additional health care benefits or services are not included in this restriction. MCOs also may not seek to influence recipients' enrollment with the MCO in conjunction with the sale or offering of any other insurance.

Other Publications

MCOs may inform MA and MinnesotaCare recipients who reside in their service areas of the availability of medical coverage through the MCO, the location and hours of service and other plan characteristics, through publications and other material distributed by the county or the State, or through mass media advertising. MCOs may provide health education materials in providers' offices. MCOs also may distribute brochures and display posters at physician offices and clinics, informing patients that the clinic or physician is part of the MCO's provider network, provided that all MCOs to which the provider subscribes have equal opportunity to be represented.

All posters, brochures and provider network-related materials must be prior approved by the State. If the materials target American Indian recipients, the State will consult with relevant tribal

governments before approval.

8.2.11 PMAP Education and Outreach

Education for county staff. DHS staff meet on a continuing basis with county groups where PMAP implementation is planned. Discussion topics include counties' general plans for enrolling the Medicaid population in managed care, problem resolution, and basic operational and systematic requirements counties will need to follow. DHS development enrollment coordinators provide on-site consultation prior to and following implementation.

New eligibles Recipients are educated about their MCO options at the time they apply for MA. These new eligibles are offered choices from the prepaid MCOs available in their respective counties. This approach to education of new eligibles facilitates a better understanding of PMAP and improves the likelihood that recipients will select MCOs that fit their medical needs.

The PMAP education and enrollment process for new eligibles is conducted either through a mail-in process or during face-to face or telephone interviews with specially trained county staff. The mail-in process includes all necessary information for a client to choose a MCO, including toll-free telephone numbers for the MCO, county worker and enrollment representative. Information in the mail-in enrollment packet includes:

- Brochure: "Your Guide to Health Plan Enrollment"
- Pre-Enrollment Questionnaire
- Flyer: "Now that I am in a Health Plan"
- Managed Care Enrollment Form
- Health Plan Options Sheet
- Flyer: "The Way You Get Your Health Care is Changing"
- Map Fold-out
- Cover Letter- indicates the client's default MCO
- Brochure: Rights and Responsibilities
- Primary Care Network List (PCNL)

An example enrollment packet is included as Attachment B.

During a face-to-face application or through telephone contact, recipients are educated about managed care and given the opportunity to choose a MCO. Enrollment materials are mailed to recipients who are not educated during the intake interview. Assignment to a MCO occurs only if the recipient does not choose a MCO within a designated time period.

Eligibles converted from fee for service (FFS) During the conversion of a FFS county

to PMAP, a different approach is taken to educating MA recipients about enrollment in managed care. Clients receive a letter 60 days prior to implementation of managed care, notifying them about changes to their health care. Two months prior to implementation, clients are notified about the opportunity to attend an informational meeting about managed care. These information sessions educate clients about managed care and allow them to choose a MCO at that time. After the informational sessions are complete, all clients who have not been educated receive the managed care information through a mass mailing. The mass mailing conversion is designed to take two to four months.

Elderly nursing facility resident eligibles PMAP education and enrollment for elderly MA recipients in nursing facilities (NFs) are sometimes handled in a manner different from the process for other eligibles. Planning and information sessions are held for personnel of NFs and provider groups who serve elderly NF residents. NFs are notified of which residents are to be enrolled in MCOs. Letters informing elderly recipients of the necessity to make a MCO selection are sent to the recipient or the recipient's authorized representative.

The county schedules a presentation at each NF site. A presenter and a county advocate conduct each presentation, and are available to answer questions about the enrollment process or changes in the program.

Outreach for potential enrollees Potential enrollees are identified prior to implementation. These clients receive notice 60 days about how their health care will be changing prior to managed care implementation. They are also sent information about scheduled managed care informational sessions at local county sites.

8.2.12 PMAP Enrollment Process

Policies

Lock-in. Once recipients are enrolled in a MCO, they must generally remain enrolled with the same MCO for a one-year period, with the following exceptions:

A. **First year of enrollment.** Enrollees may change MCO without cause once during the first year of initial enrollment, and within the first 60 days after a change in enrollment from a health plan that no longer participates in PMAP or MinnesotaCare.

B. **Good cause.** Enrollees may change MCO at any time because of problems with access, service delivery, excessive travel times or other good cause.

C. **Open enrollment.** Annually, during open enrollment, enrollees have the

opportunity to change MCOs without cause.

D. **Change of primary care provider.** Enrollees may change to a different primary care provider within the MCO's network every thirty days.

Auto-assignment method. If an enrollee does not select a MCO within 30 days, the enrollee will be assigned to a MCO using the following method:

A. Individuals who have previously been enrolled or have other household member enrolled with a MCO will be assigned to the same MCO .

B. Individuals previously enrolled with a MCO that is no longer available in the county will be randomly assigned to one of the MCOs that is available in that county.

C. Individuals who are enrolling for the first time will be randomly assigned to one of the MCOs operating in the county.

Administration: Enrollment Procedures.

Nondiscrimination. MCOs will accept all eligible recipients who select or are assigned to the MCO without regard to physical or mental condition, age, sex, national origin, health status, race or religion.

Order of Enrollment. Recipients will be enrolled in the order in which they apply or are assigned. Recipients who do not choose a MCO within the allotted time will be assigned to a MCO by the county or the State. The State may limit the number of enrollees in the MCO if, in the State's judgment, the MCO does not have capacity to serve additional enrollees.

Timing of Enrollment. Recipients may enroll with a MCO at any time during the duration of the contract between the MCO and the State.

Period of Enrollment. Each recipient will be enrolled for twelve months following the effective date of coverage, if they remain eligible, except that enrollees may change to a different MCO at open enrollment.

Enrollee Change of MCO. Enrollees may change to a different MCO during the open enrollment period, and as required under Minnesota Rules, Part 9500.1453, Subparts 5 and 7.

Enrollee Change of Primary Care Provider. Enrollees must be permitted to change to a

different primary care provider within the MCO's network every thirty days.

Open Enrollment. MCOs will enroll any eligible recipients during any open enrollment period required by the State.

Effective Date of Coverage. MCO coverage of enrollees will commence at the following times:

1. When enrollment occurs and has been entered on the State's MMIS on or before the cut off date, coverage will begin at midnight, Minnesota time, on the first day of the month following the month in which the enrollment was entered on MMIS.

2. When enrollment occurs and has been entered on the State MMIS *after* the cut off date, coverage will begin at midnight, Minnesota time, on the first day of the *second* month following the month the enrollment was entered on MMIS.

3. MCO coverage of recipients who are hospitalized in an acute care facility at the time coverage otherwise would have become effective will begin:

    a. for a MinnesotaCare or MinnesotaCare/MA enrollee during initial enrollment into managed care, on the first day after discharge from the hospital, except that eligible newborns may be enrolled in the plan effective the first day of the month of birth, even if hospitalized.

    b. for other MA and MinnesotaCare or MinnesotaCare/MA enrollees, on the first day of the month following the month of discharge from the hospital, except for eligible newborns who may be enrolled in the plan effective the first day of the month of birth, even if hospitalized.

Distribution of ID cards. Recipients will receive two ID cards. One is sent by the State, and identifies the person as a member of Minnesota Health Care Programs. Recipients also receive a card from the MCO in which they are enrolled. MCO ID cards must include the information described below, under Content of MCO Member Packets.

Administration: Disenrollment

Changing MCOs. Enrollees may change MCOs under several circumstances:

1. Enrollees may change MCOs during the annual open enrollment period.

2. Enrollees may change MCOs within 120 days following notice of a material modification of the MCO's provider network.

3. Enrollees may change MCOs because of problems with access or service delivery, or other good cause.

4. Enrollees may change MCOs once during the first year of initial enrollment in the MCO or during the first 60 days after a change in enrollment from a MCO that no longer participates in PMAP or MinnesotaCare.

5. Enrollees may change MCOs due to substantial travel time or county error.

Termination by State. An enrollee's coverage in a MCO may be terminated by the State for one of the following reasons:

1. The enrollee becomes ineligible for MA or MinnesotaCare.

2. The enrollee moves out of the MCO's service area, except in the case where the enrollee is in an inpatient facility.

3. The enrollee no longer meets enrollment criteria.

4. The contract between the MCO and the State expires or is terminated.

Effective date of termination. Notification and termination of MCO coverage will become effective at the following times.

1. When termination has been entered on the State MMIS on or before the cut off date, MCO coverage ceases at midnight, Minnesota time, on the first day of the month following the month in which termination was entered on the State MMIS.

2. When termination has been entered on the State MMIS after the cut off date, MCO coverage ceases at midnight, Minnesota time, on the first day of the second month following the month in which termination was entered on the State MMIS.

3. When termination takes place due to ineligibility for MA or MinnesotaCare, or for participation in the prepaid MA program, and the enrollee is hospitalized in an acute care facility on the effective date of ineligibility, MCO coverage ceases at midnight, Minnesota time, on the first day following discharge from the hospital.

4. When termination takes place for any other reason, including the termination or expiration of the contract between the MCO and the State, while the enrollee is hospitalized in an acute care facility, MCO coverage will cease at midnight, Minnesota time, on the first day of the month following the month of discharge from the hospital.

Reinstatement. An enrollee whose termination from the MCO has been entered into MMIS on or before the monthly cut off date may be reinstated for the following month with no lapse in coverage if the enrollee reestablished eligibility and eligibility is entered into MMIS by the last business day of the month. An enrollee whose termination from the MCO has been entered into MMIS on or before the monthly cut off date and who fails to reestablish eligibility and have it entered into MMIS by the last business day of the month will be disenrolled from the MCO for the following month unless a continuity of care issue arises and it is mutually agreed by all parties that the enrollee will be reinstated in the MCO for that following month and subsequent months. The State will pay for the month of coverage in which the Enrollee was reinstated.

Administration: MCO Responsibilities

Notice to Student Enrollees. MCOS meeting the definition of a closed panel MCO, as defined in Minnesota Statutes, Section 62Q.43, Subdivision 1, must at least annually notify full-time student enrollees under the age of 25 of their right to change their designated clinic or physician at least once per month. The MCO may require the student to give at least 15 days notice of intent to change their designated clinic or physician, and the clinic or physician must be part of the MCO'S statewide clinic or physician network.

Capability to Receive Electronically. MCOs will have the ability to receive enrollment data electronically via a medium prescribed by the State. They must provide valid enrollment data to providers for enrollee coverage verification, including pharmacy verifications, by the first day of the month and within two working days of the availability of enrollment data at the time of reinstatement. MCOs may require their providers to use the State's Electronic Verification System (EVS) to meet this requirement.

Primary Care Network List. MCOs must supply all counties within their service area, and the State for MinnesotaCare, with copies of a standardized document (known as a "Primary Care Network List, or PCNL") that provides information about the MCO's provider network and that includes a description of the essential components of the MCO, to be used by counties to educate consumers. This document must be prior approved by the State. The document must contain the following information:

1. A list of participating providers from which the enrollee must make an advance selection and their addresses, including clinics, physicians, hospitals, dentists, mental health and chemical dependency providers, nursing and skilled nursing facilities, and any provider category from which the enrollee must make an advance selection. MCOs must identify providers that are not accepting new patients in the service area. MCOs may list other affiliated providers and their

addresses, at the MCO's discretion. All primary care providers, and dental providers for whom the enrollee must select a primary dental provider, must be assigned a numeric code of up to seven digits.

2. A toll-free MCO telephone number that recipients may contact regarding MCO coverage or procedures.

3. Information about how to access mental health, chemical dependency, and medical emergency and urgent care services.

4. Information about the selection process, including a statement that enrollees must select an MCO in which their primary care provider or specialist participates if they wish to continue to receive services from that provider.

5. Any restrictions on enrollees' freedom of choice among network providers.

6. Information about free choice of family planning services and the availability of transitional services.

7. Upon request by the State, MCOs will provide information about the qualifications of mental health and chemical dependency providers.

8. Any language required by the Minnesota Department of Health (MDH) in order to provide protection and additional information for consumers of health care. Currently this language includes the following:

> "Enrolling in this MCO does not guarantee you can see a particular provider on this list. If you want to make sure, you should call that provider to ask whether he or she is still part of this MCO. You should also ask if they are accepting new patients. This MCO may not cover all your heath care costs. Read your contract, or 'Certificate of Coverage,' carefully to find out what is covered."

If the MDH determines that new language needs to be included, the MCO will incorporate it into the next available, either monthly or quarterly, printing of the PCNL.

Additional Requirements. When an MCO is new to a service area, it must provide the State with a supply of the final printed and approved PCNL, in quantities sufficient to meet the State's need for one quarter. MCOs are required to update the PCNLs as necessary to maintain accuracy. Any revisions to the PCNL must be submitted to the State along with a list of the changes, and must be approved in writing by the State before

their distribution to enrollees.

MCOs must furnish the following information to enrollees upon their request:

1. The licensure, accreditation, and certification status of the MCO or facilities in its network.

2. Information about the education, licensure, and board certification of the health care professionals in its network.

3. Information about requirements for accessing services, such as physical accessibility.

4. A list of all providers in the MCO's network, including specialty and sub-specialty providers and pharmacies.

Training and Orientation.
Counties. When a MCO or a MCO product is new to a service area, the MCO must provide training and orientation to the county, or the State for MinnesotaCare, regarding the MCO or product. The training and orientation must be provided prior to the Education Begin Date and upon request by the State thereafter. The MCO must supply the county, and the State for MinnesotaCare, with training and orientation materials to be used in educating new enrollees about the MCO. The materials must be provided 20 working days in advance of the Education Begin Date. Training and orientation materials are: lists of contacts and their phone numbers at the MCO, complete network listings or additional provider directories, if any, and organization charts.

Tribes. MCOs will provide training and orientation materials to tribal governments upon request, and will make training and orientation available for any interested tribal governments.

Additional Information. MCOs must furnish the following information to enrollees and recipients upon request:

1. The licensure, certification, and accreditation status of the MCO or the health care facilities in its network.

2. Information that includes, but is not limited to, education, licensure, and board certification of the health care professionals in the MCO's network.

3. Other information on requirements for accessing services to which enrollees are entitles, including factors such as physical accessibility.

4. A listing of all providers within the MCO's network, including specialty and sub-specialty providers and pharmacies.

Content of MCO Member Packets

Member information. MCOs must give all new enrollees the following information within 15 calendar days of the receipt of readable enrollment data from the State.

A. Certificate of Coverage. A Certificate of Coverage (COC) that has been prior-approved by the State and that will include the following:

1. a description of the MCO's medical and remedial care program, including specific information on benefits, limitations, and exclusions, and a description of how enrollee complaints are resolved, including the telephone number of the department or person handling complaints;

2. notification of the free choice of family planning services;

3. information about providing coverage for prescriptions that are dispensed as written (DAW);

4. a statement informing enrollees that, upon request, the MCO will provide a COC in the languages specified in Minnesota Statutes § 256B.692, Subd. 27. Upon the enrollee's request, the MCO must provide a COC in the enrollee's preferred language.

5. a description of how American Indian enrollees may directly access Indian Health Service and certain tribal providers, and how they will obtain referral services.

6. a description of how enrollees may access services to which they are entitled, but which the MCO does not provide.

7. a description of medical necessity for mental health services under Minnesota Statutes, Section 62Q.53.

B. Membership card. A membership card that identifies the recipient as a MCO enrollee, and that includes a MCO telephone number to contact regarding coverage, procedures, and complaints. The membership card must show that the enrollee is a recipient of Minnesota Health Care Programs, either by printing the enrollee's State PMI number on the card, or by other reasonable means. MCOs are

required to describe annually how they will ensure that enrollees and providers are aware of the different benefit sets that exist for MinnesotaCare and how to identify which copays apply.

C. **How to access services.** A description of how the enrollee may obtain services, including hours of service; appointment procedures; a list of participating providers, including clinics, physicians, hospitals, dentists and other MCO affiliated providers and their addresses and telephone numbers; prior approval requirements and procedures; and procedures for obtaining medical emergency care, urgent care, and out of plan care. The information must include a 24-hour telephone number for medical emergency services. If a MCO does not allow direct access to all primary care physician specialties, it must inform enrollees of the circumstances under which a referral may be made to such providers.

D. **Telephone number.** A toll-free telephone number that the Enrollee may contact regarding MCO coverage or procedures.

E. **EPSDT explanation.** An explanation of the MCO's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for preventive care for children.

F. **Complaints and appeals rights.** A description of all complaint and appeal rights and procedures available to Enrollees, including the MCO's internal grievance procedures, the availability of an expert medical opinion from an external organization, the ability for internal and State appeals to run concurrently, and the availability of a second opinion within the MCO.

G. **Emergency services.** A description of the MCO's obligation to assume financial responsibility and provide reimbursement for medical emergency services, post stabilization care services and out of area urgent care.

H. **Durable medical equipment.** General descriptions of the coverage for durable medical equipment, level of coverage available, and criteria and procedures for any prior authorizations, and also the address and telephone number of a MCO representative whom an enrollee can contact to obtain (either orally or in writing upon request) specific information about coverage and prior authorization. The MCO will provide more specific information to a prospective enrollee upon request.

I. **Information about physician incentive plans.** A description of the enrollee's right to request information about physician incentive plans from the MCO, including whether the prepaid plan uses a physician incentive plan that affects the use of referral services, the type of incentive arrangement, whether stop-loss

protection is provided, and a summary of survey results.

J. Results of external quality reviews. A description of the enrollee's right to request the results of an external quality review study.

Advance approval. The State must approve all new enrollment materials sent to Enrollees prior to their use. The MCO must revise its Certificate of Coverage for all substantial changes in its Complaint and Appeals procedures, and its health care delivery systems, including changes in procedures to obtain access to or approval for health care services. All revisions to the Certificate of Coverage must be approved in writing by the State in accordance with this Section and issued to Enrollees prior to implementation of the change. Approvals by the State for these materials will not be unreasonably withheld. The State agrees to inform the MCO of its approval or denial of these documents within 30 days of receipt of these documents from the MCO.

Readability Test. All English language written material disseminated by MCOs that targets recipients or enrollees, including marketing, new enrollee information, member handbooks, complaint and appeal information and other written information, must be understandable to a person who reads at the seventh grade level, using the Flesch scale analysis readability score as determined under Minnesota Statutes, §72C.09. The results of the Flesch score must be submitted to the State for approval. In addition, all materials sent to recipients or enrollees must be in at least a 10-point type size, with the exception of the ID card, which may have nonessential items in a smaller type size.

8.2.13 MCO Participation

The following types of organizations are eligible to participate in the PMAP program. At this time, the State contracts with seven health maintenance organizations (HMOs), one community integrated services network (CISN), and one health insuring organization (HIO).

Licensed health insurers Insurance companies licensed under State insurance statutes to sell policies of accident and sickness insurance.

Nonprofit health service plans Blue Cross\Blue Shield plans.

Health maintenance organizations A nonprofit corporation that provides or arranges to have provided, either directly or through arrangements with providers or other individuals, comprehensive health maintenance services to enrollees on the basis of a fixed prepaid sum without regard to the frequency or extent of services provided to any individual enrollee.

Community integrated service networks Entities licensed under HMO requirements, but exempt from some reporting requirements.

Accountable provider networks A group of health care providers organized to market health care services, and organized as a not-for-profit entity or a health care cooperative.

County-Based Purchasing entities that meet specified criteria for HMOs or CISNs (with federal approval).

8.2.14 PMAP Rate Setting

Work done by the State's actuary consultant to develop an actuarially-based approach to rate-setting served as the starting point for the State's Rate Setting methodology, summarized here.

Preliminary Rates

Base rates for FY 1996 were built up from the fee-for-service experience of prior years. The 1996 rates used the experience over a four-year period (1990 through1993) to establish a stable base to build upon. Age/sex/eligibility/area reimbursement ratios were developed based on these data. After conversion to a dollar figure, the ratios were trended forward year by year to 1993 based on price (inflation) and utilization factors in each geographic area. Third party payments were excluded from the fee-for service base, so only the state-paid reimbursements were included. To these trended data the following adjustments were added:

- stop-loss coverage by rate cell (not trended, average for four years)
- Consolidated Chemical Dependency Treatment funding for 1993
- a hospital rebasing factor to more equitably reimburse non-metro hospitals
- a trend factor for 1993 to 1996
- an access adjustment to provide funding of additional services in the non-metro area not previously provided for under fee-for-service reimbursement. This adjustment is required in legislation, and requires that the non-metro area rates be brought up to 85 percent of the metro rates
- a managed care savings factor legislated to be 10 percent for families and children and 5 percent for the aged.

Calendar Year 1998 Rates

The actuarial approach to rate-setting provides a useful structure for final rate development for subsequent years. To this structure, factors are added or removed as necessary. These factors have minor impact on overall rates, but are in the nature of "fine tuning" to meet new legislative and DHS requirements. For example, adjustments have been made for immunization services, PCA services, interpreter services, and transportation services, plan-specific participation incentives.

Calendar Year 1999 PMAP Rates

The following legislated program changes, as well as DHS-initiated changes, were considered in developing 1999 PMAP rates:

- A cost of living increase for various services, including: dental services, physician services, nursing services, home health and personal care services, and therapy services .
- Price and utilization trend factors.
- The medical education component of hospital rates was removed from MA rates.
- Ambulance service rate increase.
- The age zero to two rate cell for MFIP and the Medically Needy children was split into two rate cells: zero to one and one to two years of age.
- The component of the rates that covered abortions was removed.
- Plan-specific adjustments for DPA in Hennepin and Ramsey counties were made by DHS.

Calendar Year 2000 PMAP Rates

The following legislated program changes, as well as DHS-initiated changes, were considered in developing PMAP rates for 2000:

- MA rates included certain provider rate increases. The net increase in rates for these components was 1.5 percent.
- The price utilization trend factors were: MFIP, 0.8 percent; Medically Needy Children and Pregnant Women, 6.4 percent; and MA Elderly, 5.8 percent.
- Health plans' responsibility for the first 90 days of nursing home care for their MA enrollees was added as a PMAP benefit. The estimated value of this benefit was added to the capitation rates.
- Telemedicine consultation was a new benefit in CY 2000.
- Per 1999 legislation, regional (non-metro) rates increased from 88 to 89 percent of metro (non-Hennepin) rates.
- It was expected that the medical education component of hospital rates would be removed from the MA rates in CY 2000.
- Plan-specific adjustments for DPA in Hennepin and Ramsey counties based on hospital admission information were made by DHS.

Section Eight —MA Purchasing and Service Delivery

Calendar Year 2001 and 2002 PMAP Rates

DHS has negotiated a two-year contract with health plans covering calendar years 2001 and 2002. Rate negotiations for both years have also been concluded. Because the fee for service experience is no longer a reliable indicator of medical cost trends in PMAP, actual health plan experience was used to determine the price and utilization trends for the program. The State's actuarial consultant examined medical claims costs over four years (1996-1999) provided as part of the plans' statutory filings. An average claim cost increase was calculated, and then applied to years 2000-2002 as an estimate of projected claim costs. Rates for 2001 and 2002 used these trend factors. Using 1999 plan experience, claim costs were projected forward to 2000, and compared to actual rates increases. Using 1999 plan experience, claim costs were projected forward to CY 2000, and compared to the actual rates being paid. A 1 percent margin over claim costs was factored in to cover reserve requirements. In addition to this modest margin, any known benefit or eligibility changes in the program were estimated and included in the rate increases for 2001 and 2002.

Finally, to prevent duplication of state payment and FFP collection, DHS will adjust PMAP capitation payments, either prospectively or retrospectively, to exclude anticipated out-of-network utilization based on current claims data for IHS/636 facilities (if prospective adjustment) and actual out-of-network experience based on claims data provided under the new model (if retrospective adjustment).

Medical Education Costs

MA payments for the costs of medical education are removed from capitation payments to MCOs under PMAP and are directed to a medical education trust fund for direct distribution to teaching entities. The State has established this medical education and research trust fund through the Minnesota Department of Health. The trust fund amount is calculated as follows:

A. Each hospital's direct medical education costs from its cost report (resident and supervisor salaries and fringe benefits) is added to its indirect medical education costs, based on the Medicare indirect medical education percentage, to arrive at MERC costs.

B. The percent that MERC costs are of the hospital's inpatient payments is calculated.

C. The percent that inpatient payments are of capitation is calculated.

D. The percentages in B and C are multiplied together to arrive at the percent of capitation that is attributable to medical education costs.

On a statewide basis, approximately 4.4 percent of the MA capitation rate is derived from historical medical education payments under FFS. The MERC trust is funded at 95 percent of this amount, to assure capitation budget savings.

Distributions from the MERC trust fund are based on recommendations from a medical education and research committee of health care professionals and institutions appointed in accordance with state law. Through this process, historical medical education funds are guaranteed to remain in the medical education field. The distribution formula is based on two factors:

A. An education factor determined by the number of eligible trainees and the total statewide average costs per trainee, by type of trainee, in each program.

B. A public program factor determined by the total volume of public program revenue (MA, GAMC, PMAP, and PGAMC) received by each training site as a percentage of all public program revenue received by all training sites in the trust fund pool.

Each factor is weighted equally. Training sites that receive no public program revenue are ineligible for payments from the PMAP funding transferred to the trust fund. The list of eligible institutions and their approximate distributions is included as Attachment C.

In addition, PMAP rates were increased $5.074 million per year, and this amount is transferred to the trust fund. The Legislature has directed that these funds be distributed as follows:

- Fifty percent to the University of Minnesota Board of Regents, to be used for the education and training of primary care physicians, and efforts to increase the number of medical school graduates choosing careers in primary care.

- Twenty-four percent to the Hennepin County Medical Center for clinical education.

- Twenty-six percent to fund grants to teaching institutions and clinical training sites for projects that increase dental access for under served populations and promote innovative clinical training of dental professionals.

Further,

- Beginning July 1, 2002, PMAP rates are increased by additional $12.7 million per year; and
- Beginning July 1, 2003, PMAP rates are increased by additional $4.7 million per year.

These transfers are contingent on federal approval. These amounts are also carved out and transferred to the trust fund. The additional $12.7 million available after July 1, 2002 and $4.7 million after July 1, 2003 will be distributed to the University of Minnesota Academic Health Center for use in clinical graduate medical education.

FQHC/RHC Transition Plan

HCFA granted a waiver of §1902(a)(13)(C) to allow the State to implement a three-year transition

plan to phase out cost-based reimbursement for federally qualified health centers (FQHCs) and rural health clinics (RHCs) statewide. During this three-year transition period the State would require health plans under contract to serve MA and MinnesotaCare recipients to offer a contract to any FQHC or RHC in their service area. The waiver was approved in 1995.

During its 1999 session, the Minnesota Legislature passed legislation that brought Minnesota's schedule for phasing out cost-based reimbursement for FQHCs and RHCs into alignment with provisions of the Balanced Budget Act of 1997. As a result, the State withdrew its request for a waiver of §1902(a)(13)(c) of the Social Security Act.

In March 2001, Minnesota submitted a State Plan amendment that will bring the State into conformance with the Medicaid prospective payment system for FQHCs and RHCs under Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvements and Protections Act (BIPA) of 2000 requirements. The SPA is currently pending.

8.3 Children's Mental Health Collaboratives

The 1993 Minnesota Legislature enacted legislation permitting the formation of local collaboratives to develop integrated mental health and social services for children who have or who are at risk of severe emotional disturbance. A local collaborative consists, at a minimum, of a county agency, one or more school districts, and a mental health entity that agree to pool local funds to develop an integrated fund for the purpose of providing mental health services to children meeting the criteria included in the legislation.

The local collaborative may choose to provide mental health services to MA-eligible children within a prepaid, risk-based arrangement. For children not enrolled in a health plan, the collaborative would contract with the State to provide inpatient and outpatient mental health services for the targeted population. For children enrolled in PMAP health plans, the health plan would contract with the local collaborative to deliver the MA mental health services for children in the identified target population. The waiver authorizes MA payment on a prepaid, capitated basis for services provided by a collaborative.

Currently, no children's mental health collaboratives are operating on a prepaid, capitated basis. Ninety days prior to issuing a request for proposals to provide integrated mental health and social services for children with SED, the State will submit for HCFA review and approval a detailed description of the demonstration that addresses HCFA's December 2000 *Review Criteria for Certain Children with Special Health Care Needs in Mandatory Capitated Managed Care Programs*, as well as any subsequent guidance. The State will include all capitation rates for the project, and the methodology used to determine the rates; a detailed explanation of the MCO-collaborative contract, coordination of referrals and access to care, maintenance of patient confidentiality, utilization of services by enrollees, and the quality assurance monitoring plan.

This information will be incorporated into the State's protocol.

In addition, within 90 days of selecting a contracting local cooperative, the State will submit an implementation work plan for approval by the HCFA project officer that will specify time frames for major milestones and related sub tasks. Upon approval, this information will also be incorporated into the protocol.

8.4 Prepaid Dental Project

Under Phase 1 the State received approval of a demonstration project to test the viability and cost-effectiveness of a prepaid, capitated program for the administration and delivery of dental services to MA recipients. The waiver allows the State to purchase dental services on a prepaid, capitated basis for MA recipients who are not receiving comprehensive managed care under PMAP.

In certain areas of the state with a history of poor access to dental care, the State has realized little or no gain in access upon implementing PMAP and Prepaid MinnesotaCare. For this reason, the State is exploring alternative purchasing strategies for those areas.

The State intends to issue a request for information (RFI) for demonstration projects to improve access in those parts of the state that experience continuing poor access to dental care. Projects will involve contracts with regulated entities or local provider networks to provide the full dental benefit sets for the counties' MA, GAMC and MinnesotaCare enrollees. For these projects, the aggregated rates paid by the State for all participants will not exceed the amount the State would have paid through PMAP and Prepaid MinnesotaCare contracts. The State will maintain the existing PMAP and Prepaid MinnesotaCare contracts with the health plans, but will carve out the dental benefit and a share of the capitation that reflects increased access, placing them in the contracts of successful bidders to a request for proposals. The RFP would be developed from viable responses to the RFI.

The State is also exploring other strategies to improve dental access in other areas of the state, notably the northwest region. A separate RFI, possibly employing different strategies than those described above, may be issued in the future.

Ninety days prior to the issuance of an RFP, the State will submit for HCFA approval a detailed description of the demonstration that includes capitation rates and the methodology used in their determination; how MCOs are expected to develop linkage agreements and coordinate care for the beneficiaries; how the system will be accessed; network capability; monitoring the quality, delivery of care and access to beneficiaries; complaint and grievance procedures; and provider and beneficiary education. This information will be incorporated in the State's protocol.

Section Eight —MA Purchasing and Service Delivery

Section Nine – MinnesotaCare Purchasing and Service Delivery

9.1 MinnesotaCare Purchasing Generally

Most services for MinnesotaCare recipients are purchased through comprehensive managed care organizations on a prepaid, capitated basis. The exceptions to prepaid MinnesotaCare are:

- Services for a period of retroactive coverage are purchased on a fee-for-service basis.
- Residential rehabilitative services for children with severe emotional disturbance are purchased on a fee-for-service basis.

9.2 Pre-Paid MinnesotaCare Purchasing

9.2.1 Populations Enrolled

All of the eligible populations described in Section Five are enrolled in Prepaid MinnesotaCare plans, except for those recipients who are eligible retroactively. Services accessed during the period of retroactive eligibility are purchased on a fee-for-service basis.

9.2.2 Prepaid MinnesotaCare Coverage

All MinnesotaCare-covered services, as described in Section Seven, are purchased on a prepaid, capitated basis, except for children's residential services and retroactive coverage, which are purchased on a fee-for-service basis.

Out-of-network services. DHS has consulted with tribal governments to develop an approach to Prepaid MinnesotaCare purchasing for American Indian recipients that is different from the remainder of the program, in order to address issues related to tribal sovereignty, the application of federal provisions that prevent Indian Health Services (IHS) facilities from entering into contracts with MCOs, and other issues that have posed obstacles to enrolling American Indian/Alaska Native MA recipients living on reservations into MCOs.

American Indian MinnesotaCare recipients, whether residing on or off a reservation, will have direct access out-of-network services at IHS or 93-638 facilities. Physicians at IHS and 93-638 facilities will be able to refer recipients to specialists within the MCO's network. Enrollees may not be required to see their MCO primary care provider prior to accessing the referral specialist.

9.2.3 MinnesotaCare Marketing

Section Nine – MinnesotaCare Purchasing and Service Delivery

The marketing restrictions that apply to PMAP MCOs, described in Section 8.2.10, also apply to MinnesotaCare MCOs.

9.2.4 MinnesotaCare Education

Education
MCO education, as well as eligibility determination and enrollment, are accomplished through a mail-in process. Enrollees also have the option of coming to the MinnesotaCare office or local agency and speaking directly with an MCO enrollment staff member. When MinnesotaCare applicants are determined eligible, they receive a system-generated MCO enrollment form along with MCO primary clinic information. The form lists the MCOs that are available to enrollees in their county of residence and offers enrollees the opportunity to choose the MCO that is best for their household. The form also informs the enrollee of which MCO he or she will be assigned to if the enrollee does not select a MCO within the specified time frame. Enrollees are provided toll-free telephone numbers for the MCOs if they need further assistance.

9.2.5 MinnesotaCare Enrollment Process

Enrollment and beginning of coverage.

Date of enrollment. An applicant is enrolled with a health plan when the health plan receives the enrollment records from the State. Enrollment records are remitted to health plans at the time capitation payments are made (the eight working day before the end of each month) and at reinstatement dates (the last working day of each month).

9.2.6 MCO Participation

The State requires the same qualifications of MCOs that wish to participate in prepaid MinnesotaCare as are required of MCOs that participate in PMAP.

9.2.7 MinnesotaCare Rate Setting

The MinnesotaCare rate trend was calculated in the same way as the PMAP trend, described in Section 8.2.14. In order to allow a reasonable contribution for reserves and operational costs, rates were rebased using the most current plan experience (1999). Claim costs were trended forward to 2000 and compared to actual rate increases. A one time increase of 2.3 percent in the 2001 rates was made as a result of these calculations.

For those recipients for whom DHS is eligible to receive FFP, DHS will purchase out-of-network

services on a FFS basis using payment rates negotiated between IHS and CMS, except where a 93-638 facility elects to receive the MA rate applicable to non-tribal providers. Services by IHS or 93-638 providers to American Indian recipients for whom DHS is not eligible to receive FFP will be reimbursed on a fee-for-service basis at the usual and customary MA rate.

9.3 MinnesotaCare Prepaid Dental Project

As described in Section 8.4 for PMAP, dental services for MinnesotaCare enrollees would be purchased under a dental-only contract in conjunction with the purchase of dental coverage for MA and GAMC recipients. Prior to implementing a prepaid dental project for MinnesotaCare, the State will submit updated operational protocol detail, in accordance with the terms and conditions.

Section Ten —Quality Assurance Monitoring

10.1 Quality Assessment and Improvement

10.1.1 DHS' Quality Assessment and Improvement Strategy

DHS' quality assessment and improvement strategy includes the following elements:

- Satisfaction and disenrollment surveys
- HEDIS data collection
- Annual EQR studies
- QISMC activities
- Complaint and grievance analysis
- Special reports and studies
- Research projects conducted by DHS
- MDH annual focus studies
- MDH quality assurance examinations

10.1.2 Collaboration with MDH, MCOs, Counties, and Contractors

MCO representatives work in collaboration with DHS's Health Program Quality Division to integrate the results of these elements into the MCO's specific improvement work plan. These elements, in conjunction with DHS contract quality improvement requirements, MDH structural requirements, health plan improvement activities and established benchmarks, guide efforts to improve the health care delivery systems for the medical assistance population.

DHS meets annually with PMAP county staff to discuss issues or problems that have arisen during the previous year. DHS uses information from these meetings for policy development and contract negotiations.

A Quality Technical Committee meets monthly to advise DHS in the development of annual quality of care studies and other issues related to quality management.

To ensure that the quality of care provided by MCOs meets acceptable standards, the State monitors each MCO through an ongoing review of its quality improvement (QI) system, complaint procedure, service delivery plan, and summary of health utilization information.

10.2 Quality Assurance Standards for MCOs

MCOs are required to have internal QI systems that meet state standards set forth in the contract between the MCO and DHS. These standards are consistent with those required under state health maintenance organization (HMO) licensure requirements.

10.2.1 Internal System

Section Ten —Quality Assurance Monitoring

The MCO's system must provide for review by appropriate health professionals of the process followed in the provision of health services, utilize a system for data collection of performance and patient results, provide interpretation of such data to the practitioners and provide for instituting needed changes with identified practitioners.

10.2.2 Enrollee Satisfaction Surveys

MCOs are required to conduct enrollee satisfaction surveys through a biennial survey that meets State approval. MCOs must submit survey questions and survey results to the State by December 15 each year. MCOs are also required to participate with surveys conducted by the State or its designee.

10.2.3 Inspection

MCOs must allow the State and HCFA or their agents to evaluate, through inspection or other means, the quality, appropriateness, and timeliness of services performed.

10.2.4 External Review

MCOs are required to cooperate with an external review entity arranged for by the State in an annual independent external review of the quality of services furnished to enrollees, including providing requested medical records, data in the requested format, a copy of the sample selection logic used to frame the sample or obtain the administrative data, and other records and data necessary for the review.

10.2.5 Well-Child Visits Report

MCOs must provide an annual report detailing the MCO's progress toward meeting the federal EPSDT (Child and Teen Checkups, or C&TC) requirement. The report must follow guidelines developed by the State, and must include a description of current C&TC activities, the specific goals of each activity, an assessment of the effectiveness of the activities, and a description of changes planned in response to the assessment.

10.2.6 Financial Performance Incentives

Dental Care Incentive. MCOs may be eligible for financial performance incentive payments based on their dental services as reported in encounter data. The payment will depend upon each MCO's increased access to dental services. Increased access will be measured by a count of the number of enrollees who receive any dental service reported on an ADA claim form, divided by the total number of enrollee-months. This ratio will be compared to the same measure reported in managed care plans the prior year.

Well-Child Primary Care Accessibility Incentive. MCOs may be eligible for financial performance incentive payments based on their well-child services for new enrollees under the age of 18, who receive such a visit within 60 days of enrollment, as reported in encounter data. The payment will depend upon each MCO's increase in the number of well-child visits received over the number in the prior year.

The MCO may receive three distinct payments, including:

- **Well-Child Visits.** If the MCO exceeds its well-child access rate of calendar year 1999 for the contract year 2001 and the well-child access rate of calendar year 2001 for contract year 2002, the MCO may receive an incentive payment for each well-child visit above the prior year's percent of children receiving such visits.

- **Children Newly Enrolled in Managed Care.** The MCO will receive an incentive payment for each newly enrolled children age one through age 20, with age determined as of 12/31/01 and 12/31/02 for each respective contract year, to whom it provides a well-child visit within 180 days of enrollment.

- **Lead Screening.** The MCO may receive incentive payments if it provides an initial blood lead test, as defined by the State, to children age nine months through age 30 months for each unduplicated child above the percentage amount of children tested in calendar year 1999 for contract year 2001 and calendar year 1999, for contract year 2002.

10.2.7 Documentation of Care Management

MCOs must maintain documentation sufficient to support their care management responsibilities. MCOs are required to make available to the State, or the State's designated review agency, access to a sample of enrollee care management plans upon request.

10.3 Quality Monitoring Methodologies

10.3.1 Quality Assurance Examinations

Quality assurance examinations are conducted by MDH, and consist of the following modules.

Administration, QA program and activities.

Written QA plan	Ongoing quality evaluation
Documentation of responsibility	Scope
Appointed entity	Problem identification

- Physician participation
- Staff resources
- Delegated activities
- Information system
- Program evaluation
- Complaints
- Utilization review
- Provider qualifications & selection
- Qualifications
- Medical records
- Problem selection
- Corrective action
- Evaluation of corrective action
- Focused studies
- Topic identification and selection
- Study methodology
- Corrective action from focused studies
- Other studies
- Written annual work plan and amendments

Complaints.

- Complaint system
- Records and complaint log
- Denial and coverage
- Dispute resolution
- Expedited resolution

Availability and accessibility.

- Service area
- Geographic accessibility
- Coordination of care
- Access to emergency care
- Basic service
- Geographic exceptions
- Timely access
- Continuity of care

Utilization review.

- Obtaining certification
- Utilization information
- Data elements
- Written procedures
- Notification of determination
- Appeal procedures
- Confidentiality
- Staff and program qualifications
- Staff training
- Physician consultants
- Prohibition of inappropriate incentives

10.3.2 External Review

External audits of the quality of care provided by contracted MCOs have been conducted since 1988 by various organizations under contract with DHS. In addition, DHS gains information from other advisors:

Enrollee satisfaction survey. DHS conducts a CAHPS 2.0H consumer satisfaction survey of its managed care and fee for service enrollees on a biennial basis. Enrollee participation in the survey is entirely voluntary and confidential. The CAHPS survey instrument was selected because it is a

standardized survey instrument that has undergone extensive development by the U.S. Agency for Health Care Quality and Research to help consumers identify the best health care plans and services for their needs. The instrument consists of approximately 63 core questions, with the addition of 12 questions from the SF-12– survey to assess functional status. An independent survey organization is selected to conduct the survey, consistent with CAHPS recommended data collection methodologies.

Quality assessment and improvement strategy. DHS's quality management strategies provide for annual studies and data collection to monitor and assess the quality of care and services provided to all program enrollees. Structural and operational standards described in State statutes and rules provide the foundation for quality assurance examinations conducted at least every three years by the Minnesota Department of Health (MDH) through an interagency agreement between DHS and MDH. Annual performance monitoring standards such as HEDIS data collection, QISMC quality improvement intervention assessments and State specific performance improvement projects provide a broad-based integration of methods to monitor and guide the development and delivery of quality health care services. The results of performance measures of service and clinical care are compared to national benchmarks and health plan trends over time. External Quality Review studies are conducted by DHS on selected quality of care and services measures to assess the individual health plan performance (see attached list of EQR studies). Results of these activities are published and distributed widely throughout the State and it's many consumer advocate representatives.

10.3.3 Quality Improvement Plans

When annual quality of care studies are completed, areas needing improvement are identified. Each MCO develops a Quality Improvement Plan (QIP) describing how the areas designated for improvement will be addressed. DHS staff monitor MCO progress in meeting the goals established in the QIP at six month intervals.

10.3.4 Disenrollment Survey

DHS mails disenrollment surveys on a monthly basis to enrollees who disenrolled by exercising their one- time change option or changing MCOs at open enrollment. Survey results will be summarized and sent to the Health Care Financing Administration in accordance with physician incentive plan (PIP) requirements. Survey results will also be provided to consumers who request the information and to MCOs and other interested parties, subject to data privacy limitations.

10.4 Complaint and Grievance Systems

PMAP and MinnesotaCare enrollees who have problems receiving medically necessary care or

have billing issues have an external appeal process. Enrollees have the right to a complaint procedure within the MCO and to an external appeal process through DHS. In addition, enrollees have the right to request external review through the Minnesota Department of Health if their internal appeal is denied. Written notice to enrollees or anyone authorized to act on behalf of an enrollee of health maintenance organizations must include the following information:

- An explanation, in clear terms understandable to a layperson, of what was denied.
- An explanation of the specific reason for the denial.
- A statement describing the right to external appeal and how to request an appeal.
- A statement explaining expedited appeal rights and how to request an expedited appeal.
- A statement directing questions to the Managed Care Systems Section, Minnesota Department of Health.

The time frame for a normal external appeal is 40 days. The State has also required its contractor to provide expedited appeals (in 72 hours or less) on similar terms as apply to Health Plan requirements for internal expedited appeals (62M.06).

County advocates are required to assist PMAP enrollees with these issues and MinnesotaCare enrollment representatives assist MinnesotaCare enrollees. The Office of Ombudsman for State Managed Care Programs assists PMAP and MinnesotaCare enrollees to resolve MCO or service delivery issues.

10.4.1 Notification Requirements

Each enrollee receives a Notice of Rights and Responsibilities with the initial enrollment notification letter and with each notice of open enrollment. The state ombudsman or county staff may send the rights notice to enrollees who contact them for complaint resolution.

An explanation of the complaint and appeal process is included in the health plan member materials. Every health plan member receives a Certificate of Coverage (COC). The COC explains the plan's and the State's complaint and appeal procedures and the right to a second medical opinion within the plan.

MCOs must notify enrollees when services are denied, reduced, or terminated, by a written form letter (DTR) that must be reviewed by DHS prior to implementation. If the MCO proposes to reduce or terminate the enrollee's ongoing medical services and a MCO provider has ordered the service, the written notice must be provided at least 10 days in advance of the proposed MCO action. If the enrollee files an appeal with DHS, the MCO may not take the proposed action until a written decision is issued by the State. MCOs must send copies of all DTR notices, or a state-approved monthly compilation report, to the DHS ombudsman. The DTR must include:

1. the specific action being taken,

2. the type of service or claim that is denied, terminated, or reduced, including common carrier transportation oral and written denials,
3. the reason for that action,
4. the state or federal laws and health plan policies that support the health plan action,
5. an explanation of the enrollee''s right to:
   - file a complaint with the health plan and/or
   - request a hearing with the state
   - request a second opinion
   - request an expedited determination

6. the circumstances under which the medical service will be continued if a hearing is requested

10.4.2 MCO Complaint and Grievance Processing

Health Plan Internal Complaint Process. Each health plan must identify in its COC a description of all complaint and appeal procedures available to enrollees, including the health plan's internal complaint procedure. The health plan's internal complaint procedure must consist of an informal and formal structure for reviewing enrollee complaints. The internal complaint process must include adjudication of complaints made by providers on behalf of enrollees, with the enrollee''s consent.

An enrollee may initiate an informal complaint either on the telephone or in person. The health plan must respond to an informal complaint within ten (10) calendar days of receiving the complaint.

The formal complaint procedure is initiated by a written complaint from the enrollee or the authorized representative. The health plan must notify the ombudsman within three working days after an enrollee files a written complaint. When a formal complaint is filed, the health plan may do an internal review or conduct a formal hearing. A determination must be made within thirty calendar days from the date of receiving the written complaint.

The health plan must provide the petitioner with a written resolution within the 30-day time frame. Information regarding the State appeal process and the telephone number of the ombudsman must be sent with the determination.

Each health plan has specific procedures for responding to a formal complaint. The health plan must include the opportunity to receive an expedited determination. The COC contains a detailed explanation of the health plan's complaint process.

Appeal to State. Enrollees have the right to file an appeal with DHS any time during the complaint process. After an appeal is filed, the appeal hearing is scheduled within a few weeks.

DHS' appeals referees conduct the hearing and an order is written within ninety days after the appeal hearing. Enrollees have the option of filing a complaint with the MCO, appeal to DHS, or use both complaint procedures simultaneously.

Expedited appeals. There are two expedited appeal processes. If urgently needed care is denied by the plan, the enrollee or his or her designated representative may request an expedited appeal through the plan. The MCO is required to respond with a decision within 72 hours. The second expedited appeal is through the DHS hearing referees. If the enrollee requests an expedited appeal, referees write their orders within thirty days.

Judicial review. If an enrollee disagrees with the determination of the State resulting from an appeals hearing, the enrollee may seek judicial review in the district court of the county of service.

Second opinions. MCOs must provide for a second medical opinion within the plan at the enrollee's request. MCOs are required to comply with a DHS referee's order for a second opinion, either by the MCO or by a non-MCO provider, at the MCO's expense.

MCOs must promptly evaluate the treatment needs of an enrollee who is seeking treatment for a problem related to mental health conditions. If the MCO or a participating provider determines that no type of structured treatment is necessary, the enrollee is immediately entitled to a second opinion, paid for by the MCO, by a health care professional qualified in diagnosis and treatment of the problem and not affiliated with the MCO. The health maintenance organization or participating provider must consider the second opinion and document its consideration, but is not obligated to accept the conclusion of the second opinion.

A client who disagrees with the level of care proposed by a chemical dependency assessor has the right to request a second chemical use assessment. The county or the MCO must inform the client in writing of the right to request a second assessment at the time the client is assessed for a program placement. The county or MCO must also inform the client that the request must be in writing or on a form approved by the commissioner, and must be received by the county or MCO within five working days of completion of the original assessment or before the client enters treatment, whichever occurs first.

The county or MCO must provide a second chemical use assessment by a different qualified assessor within five working days of receipt of a request for reassessment. If the client agrees with the second level of care determination, the county or MCO must place the client in accordance with the second assessment.

10.4.3 State Appeals Process

Enrollees may file appeals directly with DHS. An appeal hearing is conducted by an appeals referee and an order is written within thirty to ninety days after the appeal hearing. Although

enrollees are encouraged to exhaust the MCO's complaint procedure before filing an appeal to DHS, enrollees have the right to deal directly with the State or to pursue both complaint procedures simultaneously. Enrollees have the right to appeal:

- participation in a prepaid program,
- the denial, termination, or reduction of services,
- nonpayment of bills relating to services already provided,
- an appeal of an MCO's resolution to a complaint, or
- requirement to participate in a health plan because of excessive travel time or agency error.

State Appeal Process. The State appeal process gives enrollees the right to appeal issues regarding enrollment in an MCO and issues about services that are denied, terminated, or reduced.

Types of State Appeals. There are two types of state appeals for enrollees: Administrative appeals, including appeals of mandatory participation and appeals to change health plans outside the authorized time frames; and service appeals.

State Appeal of Mandatory Participation. An enrollee may appeal mandatory participation in an MCO and request to remain on or return to fee-for-service MA through the state appeal process. Enrollees who wish to appeal mandatory participation are referred to the county advocate or State ombudsman. The advocate or ombudsman describes the appeal procedure and may suggest other options, such as changing health plans when the option is available.

Enrollees may send a letter of appeal or may request an appeal form from the county office, the Managed Health Care Ombudsman, the DHS appeals office, or the MinnesotaCare office. When the recipient returns the completed appeal form, the State ombudsman logs the appeal into the database and forward it to the Department appeals unit.

The appeals unit schedules a hearing within two to three weeks of receiving the appeal request. An administrative hearing officer from the appeals unit conducts the hearing. The enrollee must attend the scheduled hearing or cancel before the hearing date, or will lose the right to appeal.

The enrollee has a right to legal assistance. Legal Aid telephone numbers are made available to the enrollee when the initial request for an appeal is made. Within ninety days the enrollee will receive written notification regarding the outcome of the appeal hearing.

Appeals to change MCO. An enrollee may file an administrative appeal to request a change of health plan outside the first year option or the open enrollment period either because of inaccessibility – travel time to the primary care provider in the metro area is more than thirty minutes (or is less than thirty minutes, but considered excessive by enrollee), or in the non-metro

area, considered excessive by community standards – or because the enrollee's health plan was incorrectly designated due to local agency error.

If an enrollee wishes to change MCOs for one of these reasons, the county informs the enrollee that an appeal form must be completed. The State ombudsman conducts a review and notifies the county if an enrollment change is approved. The county will then process the enrollment in the usual manner.

State Service Appeal Process. An enrollee may appeal:

- an MCO's decision to deny, terminate, or reduce services
- an MCO's resolution of a complaint
- other problems regarding MCO services
- bills incurred by the enrollee, for which payment was denied by the MCO
- any other decision of an MCO.

For appeals involving service issues, enrollees may be referred to a county advocate or ombudsman who can assist in resolving the complaint. An appeal must be filed within **30 days** after the health plan sends a notice for denial, termination, or reduction of services.

10.4.4 County Advocates

Each county participating in PMAP has advocacy staff available to assist enrollees in resolving problems associated with participation in a PMAP MCO. The county advocates help enrollees to articulate their complaints and assist PMAP enrollees in making informed decisions regarding options to pursue in order to satisfactorily resolve those complaints. In addition, county advocates provide assistance in filing grievances through both formal and informal processes, and are available to assist in the appeal process, including attending appeal hearings. State ombudsmen and county advocate staff meet monthly to identify complaint and appeal trends and cooperate in resolving problematic cases.

County Advocate Role - General When enrollees contact the county with a complaint about an MCO, county advocates may:

- Gather initial information from the enrollee to learn more about the issue.
- Verify eligibility status, date of enrollment in the health plan, etc.
- Determine what remedy the enrollee seeks.
- Send a letter to the enrollee to explain the role of the county advocate and information about appeal rights.
- If requested, assist the enrollee in gathering information necessary to resolve the problem, including contacting the health plan, gathering pertinent information, or contacting other parties, such as providers.

- Assist the enrollee in writing a letter to the health plan, if a written internal complaint has not been filed. The letter should include the specific remedy requested. The Department monitors the MCO's response.

If resolution cannot be achieved, or the enrollee wishes to file an appeal through the Department immediately, the enrollee must complete and sign a State Appeal Form and a Request for Release of Medical Information form. The county advocate sends the ombudsman the signed appeal form, and the ombudsman enters the information into a tracking system, which is used to monitor the type and outcome of all appeals.

The enrollee or the county advocate may request an expedited appeal hearing when a resolution is needed without delay. The expedited hearing is conducted within two weeks of receiving the signed appeal form. Hearings are generally conducted by telephone, unless the enrollee requests an in person hearing.

County Advocate Role - Appeals. When an enrollee decides to file a service appeal, the county advocate will:

1. Explain the state appeal process.
   - The hearing is held either at a county office or by telephone. A DHS appeal referee conducts the hearing.
   - The enrollee has the right to representation by a family member, friend, social worker, advocate, attorney or other interested party.
   - The enrollee, with the assistance of the county advocate, is responsible for providing evidence to support the case.

2. Send necessary forms to the enrollee to complete and sign.
3. Inform the health plan about any complaint or appeal that relates to service. The county must notify the health plan when an appeal is filed without using the health plan's internal process.

4. Assist the petitioner to: gather documentation, such as case summaries, medical records, letters from providers, letters of denial from the health plan, case notes, COC, DHS rules, or appropriate statute citations; obtain witnesses; and help the enrollee prepare opening and closing remarks for the hearing.

5. If requested, assist or represent the enrollee at the hearing and after a ruling is made in the case.

10.4.5 State Ombudsman Program

Section Ten —Quality Assurance Monitoring

The Office of Ombudsman for State Managed Care Programs was created to assist enrollees in PMAP and MinnesotaCare. The Ombudsman Office works through the complaint and appeals process to ensure that enrollees receive medically necessary health care services. The ombudsmen are familiar with MCO contracts and can act as mediators or negotiators in resolving enrollee complaints regarding health care delivery and billing issues.

Role of State Ombudsman. The Commissioner of Human Services designates the State ombudsman to advocate for people required to enroll in prepaid health plans. The ombudsman may assist enrollees in resolving service related problems with the health plan. If requested by the enrollee, the ombudsman must investigate the enrollee's complaint and attempt to resolve the problem informally. The ombudsman serves as an intermediary between the enrollee and the health plan. The ombudsman must explain to the enrollee:

- complaint and appeal options,
- how to file a complaint or appeal,
- how to obtain a second opinion from the health plan,
- how to file an expedited appeal, and
- how the complaint and/or appeal process functions.

If a complaint cannot be resolved informally, the ombudsman may assist the enrollee in filing a formal complaint or appeal request.

Relationship Between the Health Plan and the Ombudsman. The MCO must notify the ombudsman of any formal complaint filed by an enrollee within three working days of receiving the complaint. When a health plan denies, terminates, or reduces a health service or denies payment for a service, it must send notification to the enrollee of the right to file a complaint or appeal with the State. This notice must include phone number of the State ombudsman.

10.5 Fraud and Abuse Activities

10.5.1 Surveillance and Integrity Review Program

Procedures used by DHS in identifying and investigating fraud, theft, or abuse by vendors or recipients of health services through the PMAP and prepaid MinnesotaCare programs are established in State rules. Standards for the health service and financial records of vendors of health services through those programs are also established in rule. In general, the health service must be documented in the recipient's health service record. Program funds paid for a health service that is not documented are recovered by the State.

Health services records. Vendors are required to keep detailed health service records. Additional requirements are in place for laboratory or X-ray services, pharmacy service, medical transportation, medical supplies and equipment, personal care provider services

Financial records. Vendors who receive payment under PMAP or prepaid MinnesotaCare must maintain detailed financial records. Long-term care facilities must also maintain purchase invoices and records of the deposits and expenditure of funds in the recipients' resident fund accounts.

Vendors are required to retain all health service and financial records related to services for which payment under PMAP or prepaid MinnesotaCare was received or billed for at least five years after the initial billing date.

Department investigation. The department investigates vendors and recipients to identify fraud, theft, or abuse in the administration of the programs. In conducting its investigation, the department may contact any person, agency, organization, or other entity necessary to an investigation.

The department's authority to investigate extends to examination of any person, document, or thing which is likely to lead to information relevant to the expenditure of funds, provision of services, or purchase of items, provided that the information sought is not privileged against such an investigation by operation of any state or federal law.

At the conclusion of an investigation, the department determines whether the evidence of fraud, theft, or abuse supports administrative, civil, or criminal action. The department is authorized to take one or more of the following actions:

- Impose administrative sanctions.
- Seek monetary recovery.
- Refer the investigation to the appropriate state regulatory agency.
- Refer the investigation to the attorney general or, if appropriate, to a county attorney for possible civil or criminal legal action.
- Issue a warning that states the practices are potentially in violation of program laws or regulations.

10.5.2 Requirements of MCOs

Integrity Program. MCOs are required to establish integrity programs that meet the requirements of 42 C.F.R, Parts 456.3 and 456.23, including:

1. Profiles of provider services and recipient utilization, identifying aberrant behavior or outliers.

2. Safeguards against unnecessary or inappropriate use of services and excess payments for services.

3. Safeguards against failure by subcontractors or providers to provide medically necessary covered services.

4. Identification, investigation, and corrective action against fraudulent and abusive practices of providers, subcontractors, enrollees, or MCO employees, officers, or agents.

MCOs are required to document all activities and corrective actions taken under their integrity programs. They must identify a contact person responsible for implementation of the program, and must report annually, in writing, to the State all integrity program information.

Fraud and abuse by an MCO or its subcontractor. MCOs and their subcontractors are required to make available to the Minnesota Medicaid Fraud Control Unit (MFCU) of the Minnesota Attorney General's Office any records related to the delivery of items or services under a PMAP contract, upon the request of MFCU. MCOs must allow the MFCU access to these records during normal business hours.

MCOs are required report to the State and MFCU any suspected fraud or abuse by providers within 24 hours after the MCO knows or has reason to believe that fraud or abuse has taken place. MCOs are required to cooperate fully in any investigation by the State and MFCU.

Fraud and abuse by enrollees. MCOs must also report to the State any suspected fraud or patterns of abuse by enrollees.

Managed care organizations are regulated jointly by the Minnesota Department of Health and the Minnesota Department of Commerce. Areas of regulation and required documentation are described below.

11.1 Organization and Operations; Conflicts of Interest

MCOs must provide a copy of any basic organizational document, such as articles of incorporation, for the MCO and for each major participating entity. MCOs must provide a copy of any bylaws, rules and regulations (or other similar documents) that regulate the rules of conduct of the affairs of the MCO and any major participating entities. MCOs must provide the following information regarding the members of the governing board and any major participating entity:

1. The names, addresses and official positions of all members of the governing board of the MCO.
2. The names of the members of the governing body who own more than ten percent of any voting stock of any major participating entity.

3. The names of the principal officers of each major participating entity who own more than ten percent of any voting stock of any major participating entity.
4. An organizational chart for the MCO showing the names of staff members and their responsibilities.

MCOs are required to provide a full disclosure of the extent and nature of any contract or financial arrangements between the following:

1. The MCO and any member of the governing board of the MCO.
2. The MCO and the principal officers of each major participating entity who own more than ten percent of any voting stock of any major participating entity.
3. Each major participating entity and any member of the governing board of the MCO, concerning any financial relationships with the MCO.
4. Each major participating entity and the principal officers of each major participating entity who own more than ten percent of any voting stock of any major participating entity, concerning any financial relationship with the MCO.

MCOs are required to provide the following information regarding potential conflicts of interest:

1. A copy of the conflict of interest policy applicable to all members of the governing board and principal officers of the MCO. The conflict of interest policy must contain the procedures described in MINN. STAT. §317A.255, Subds. 1 and 2.
2. Evidence that each member of the governing board has signed the policy.

MCOs must provide evidence that they will meet the requirements of MINN. STAT. § 72A.201, concerning the regulation of claims practices. If the MCO purchases claims processing services from another entity, it must also provide a copy of the signed contract between the MCO and the claims processing entity.

11.2 Complaint System; Utilization Review System; Prior Authorization Procedures

MCOs must provide the following information related to their internal complaint procedures, utilization review and prior authorization administrative procedures:

1. A description of the MCO's internal complaint procedures, which must meet the requirements of MINNINNESOTA. STATUTES § 62D.11, MINNESOTA RULES 4685.1700, and MINNESOTA RULES 4685.1900. The complaint process must incorporate the utilization review requirements of MINNESOTA STATUTES § 62M. MINNESOTA

STATUTES § 62D.03, Subd. 4 (n). The complaint system must include the following provisions:

- Internal complaint system requirements
- Expedited resolution of complaints about urgently needed services;
- Maintenance of complaint records, and;
- Denial of service procedures.

2. A description of the MCO's plans for meeting the utilization review requirements of MINNESOTA STATUTES § 62M, including the specific provisions listed below. If the MCO purchases utilization review services from a licensed utilization review organization, it must provide a copy of the signed agreement between the parties and evidence of the entity's licensure as a utilization review organization.

   - Standards for utilization review performance;
   - Procedures for review determination;
   - Appeals of determinations not to certify;
   - Confidentiality;
   - Staff and program qualifications;
   - Accessibility and on-site review procedures;
   - Complaints to the Department of Health; and,
   - Prohibition of inappropriate incentives.

3. A copy of the MCO's prior authorization procedures, as described in MINNESOTA STATUTES § 62M.07 and required by MINNESOTA STATUTES § 62D.03, Subd. 4 (s), including:

   - Written procedures and criteria used to determine whether care is appropriate, reasonable, or medically necessary;
   - A system for providing prompt notification of its determination to enrollees and providers and for notifying the provider, enrollee, or enrollee's designee of appeal procedures;
   - Compliance with MINNESOTA STATUTES § 72A.201, subdivision 4 (a), regarding time frames for approving and disapproving prior authorization requests, and;
   - Written procedures for appeals of denials of prior authorization that specify the responsibilities of the enrollee and provider.

11.3 Quality Assurance Systems

Section Eleven —Oversight of Managed Care Organizations

MCOs are required to provide the following information to demonstrate that they are in compliance with quality assurance statutes and rules:

1. A written quality assurance plan, including:

   - Mission statement;
   - Philosophy;
   - Goals and objectives;
   - Organizational structure;
   - Staffing and contractual arrangements;
   - System for communicating information regarding quality assurance activities;
   - Scope of quality assurance program activities, and;
   - Description of peer review activities.

2. The written quality assurance plan must also provide detailed explanations of the following provisions:

   - Documentation of responsibility;
   - Designation of an appointed quality assurance entity;
   - Physician participation in quality assurance implementation;
   - Sufficient staff resources;
   - Delegation of responsibilities;
   - Adequate information system;
   - Annual program evaluation;
   - Evaluation of quality of care complaints;
   - Analysis of utilization review activities;
   - Policies regarding provider qualifications and selection;
   - Adequate staff or contractee qualifications, and;
   - Ongoing evaluation of medical records.

3. MCOs are required conduct ongoing quality assurance evaluations that include clinical, organizational and consumer components. The evaluations must include problem identification, problem selection, corrective action; and evaluation of corrective action.

11.4 Accessibility Standards; Provider Contracts; Locations of Providers

A. Provider Contracts. MINNESOTA STATUTES §62D.123 require MCOs to provide the name and address of each provider with which the MCO has signed a contract or

agreement and a copy of each signed contract or agreement between each provider and the MCO.

B. **Essential Community Providers**. MCOs are required to offer a provider contract to all essential community providers (ECPs) located within the MCO's service area. The provider contract must be substantially similar to those offered to MCO providers who provide the same type of service. In addition, the negotiated rate must be the same rate per unit of service as is paid to other MCO providers for the same or similar services. MCOs must infor their enrollees that the ECP is available to provide designated services to under served, high risk, and special needs populations.

C. **FQHCs and RHCs Contracting Requirements.** If an MCO negotiates a provider agreement or subcontract with a federally qualified health center (FQHC) as defined in Section 1905(l)(2)(B) of the Social Security Act, 42 U.S.C. Section 1396d(l)(2)(B), or a rural health clinic (RHC) as defined in 42 C.F.R. 440.20, the negotiated payment rates must be comparable to the rates negotiated with other subcontractors who provide similar health services. The State may require the MCO to offer to contract with any FQHC or RHC in the MCO's service area. The MCO is not required to pay any settle-up payments in addition to the negotiated payment rate.

D. **Nonprofit Community Health Clinic, Community Mental Health Centers, and Community Health Services Agencies Subcontracting Requirements.** MCOs are required to contract with nonprofit community health clinics (community health clinic), community mental health centers, or community health services agencies to provide services to enrollees who choose to receive services from the clinic or agency, if the clinic or agency agrees to payment rates that are competitive with rates paid to other MCO providers for the same or similar services, pursuant to MINNESOTA STATUTES §256B.69, Subdivision 22. MCOs may require a clinic or agency to comply with the same or similar contract terms that the MCO requires of other participating providers, except that the MCO cannot exclude coverage for a covered service provided by a clinic or agency in a subcontract with a clinic or agency. The State provides MCOs with a list of all such clinics and agencies within the service area.

E. **Home Visiting Services**. MCOs are required to contract with programs receiving grants under MINNESOTA STATUTES §145A.16: Universally Offered Home Visiting Programs for Infant Care, for covered home visiting services. MCOs may require a home visiting program to comply with the same or similar contract terms that the MCO requires of its other participating providers. The State provides MCOs with a list of all existing home visiting programs receiving grants within the service area within one week of the effective date of a contract, and as soon as possible after establishment of any home visiting programs.

F. Children's Mental Health Collaborative. MCOs must subcontract with a children's mental health collaborative organized under Minnesota Statutes that has an approved integrated services system, has entered into an agreement with the State to provide MA or MinnesotaCare services, is capable of providing inpatient and outpatient mental health services in return for an actuarially based capitated payment from the MCO, to be determined by the State, and requests to become a subcontractor. MCOs must allow enrollees who meet the membership requirements of the collaborative the choice to receive mental health services through either the collaborative or the MCO, and must work cooperatively with the collaborative to assure the integration of physical and mental health services to enrollees of the collaborative. The collaborative must be willing to hold the MCO harmless from all liability of any kind associated with the collaborative's performance. The MCO may require the same or similar contract terms that it requires of its other subcontractors.

G. Adequacy of Access. MCOs must define their geographic service areas and demonstrate that they provide adequate access to comprehensive services within those areas by providing the following:

- A detailed map with the proposed service area outlined.
- Provider locations charted on the map.
- A description of the driving distances, using major transportation routes, from the borders of the proposed service area to the participating providers.
- A description of the providers' hours of operation.
- Evidence that the physicians have admitting privileges at the hospitals that enrollees in the proposed service area will use.
- The name, address and specialty of each provider in the proposed service area.
- Evidence that comprehensive health maintenance services are available to enrollees on a 24-hour per day, seven days per week basis within the proposed service area.

MCOs must ensure that waiting times:

- For primary care appointments will not exceed 45 days for routine and preventive care, or 48 hours for urgent care.
- For dental, optometry, Lab, and X-ray services, will not exceed 60 days for regular appointments, or 48 hours for urgent care
- For a specialist, will be in accordance with the needs of the enrollee, and consistent with generally accepted community standards.

MCOs are required to have a system in place for the confidential exchange of enrollee information when a provider other than the primary care provider delivers health care services to the enrollee.

MCOs must require all affiliated providers to meet the access standards described in this section and in applicable state and federal laws. MCOs must monitor, on a periodic or continuous basis, but no less than every 12 months, the providers' adherence to these standards.

H. **Changes in network or service area.** MCOs must notify the State as soon as possible of significant events affecting the level of service either by MCO or its providers or subcontractors. The MCO must notify the State of a possible material modification in its provider network within ten working days of the date the MCO has been notified that the modification is likely to occur. A material modification must be reported to the State no less than 120 days prior to the effective date. A MCO may terminate a sub-contract without 120 days notice if the termination is for cause.

I. **Access if a provider contract is canceled.** MCOs must prepare a written plan that provides for continuity of care in the event of contract termination between the MCO and any contracted primary care or general hospital providers. The plan must explain how the MCO will:

- Inform enrollees about the termination at least 30 days before termination is effective;
- Inform the enrollees about available providers and transfer enrollees to new providers while maintaining continuity of care;
- Transfer enrollees who have special medical needs, special risk or other special circumstances that require a longer transition;
- Identify those enrollees with special medical needs or special risk, describe how continuity of care will be provided for such enrollees, and whether the MCO has contracted this responsibility to its contracted primary care providers.

J. **Systems for addressing needs of special populations.** See §6.4, Serving Minority and Special Needs Populations

11.5 Network Adequacy

MCOs are required to develop standards for appointment times, waiting times, and ratios of providers to patients

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Written Plans. MCOs must prepare written plans that provide for continuity of care in the event of contract termination between the MCO and any of the contracted primary care providers or general hospital providers.

Notice to Enrollees. MCOs must provide prior written notification to enrollees who will be affected by a network modification. The notice must inform each affected enrollee either that one of the primary care providers they have used in the past is no longer available and they must choose a new one from the MCO's remaining choices, or that the enrollee has been reassigned from a terminated sole source provider. In either case, the MCO must inform affected enrollees of their opportunity to disenroll and change MCOs up to 120 days from the date of notification, unless open enrollment occurs within 120 days of the date of notification. MCOs must fully cooperate with the State and county to facilitate a change of MCO for affected enrollees.

Provider Access Changes. MCOs may not make any substantive changes in the way enrollees must choose primary care providers and physician specialists without advance approval by the State.

Monitoring the adequacy of the provider network. The Minnesota Department of Health (MDH), as part of its licensing function, reviews the adequacy of MCOs' provider networks.

DHS staff maintain a primary care network map which effectively depicts the location of all MCO primary care clinics by MCO. In evaluating the adequacy of this network, DHS staff review the distances enrollees must travel in order to obtain care. Any MCO that does not meet the MDH criteria (30/60 miles) will be available by choice to enrollees but enrollees will not be auto-assigned to these MCOs through the default enrollment process.

DHS contracts with MCOs include provisions relating to the material modification of provider networks. A MCO must notify DHS of a possible material modification in its provider network within 10 working days from the date the MCO has been notified that a material modification is likely to occur. A material modification is defined as a change that would result in an enrollee having only three remaining choices of a primary care provider within 30 miles or 30 minutes, a change that results in the discontinuation of a primary care provider who is responsible for the primary care physician services for 1/3 or more of the enrollees in the applicable area, or a change that involves a termination of a sole source service provider where the termination is for cause.

DHS works with county staff to solicit input in the selection of MCOs during the RFP process. County staff are knowledgeable about local care systems, and identify any missing providers or provider groups. DHS uses this information to select MCOs and to work on network development with those MCOs that are selected.

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As PMAP is expanded to new regions of the state, a series of post-implementation meetings is scheduled for the expansion region. These meetings are designed to facilitate good communication between MCOs and counties. Any network or access issues are addressed at these meetings. Post-implementation meetings are usually continued for at least one year after implementation. DHS encourages MCOs and counties to continue to work together, and post-implementation meetings are continued past one year if requested by the county or the MCO.

Annually, prior to contract negotiations, a series of county input meetings is scheduled to allow each PMAP county the opportunity to share with DHS any areas of concern with MCO operations in its area. County staff involved in these meetings include representatives from public health, mental health, social services, county advocacy, etc.

DHS does a disenrollment survey of all enrollees who change MCOs, and MCOs are required to measure enrollee satisfaction annually through a survey. The results of these surveys are used by DHS contract management staff to identify network or other problems.

Future enhancements to DHS review of network adequacy will include:

- Mapping of MCO behavioral health providers statewide.
- Requiring that each MCO submit regular reports of providers who are unable to accept new patients
- More extensive review and mapping of specialty care (the majority of specialty providers are co-located with primary care providers).

11.6 Geographic Accessibility

Travel times or distance standards for primary and specialty care.

- The maximum travel distance or time within the MCOs service area to the nearest primary care provider or general hospital must be the lesser of 30 miles or 30 minutes.
- The maximum travel distance or time within the MCOs service area to the nearest provider of specialty physician services, ancillary services, specialized hospital services, or any other health services must be the lesser of 60 miles or 60 minutes.

Exceptions to geographic standards. Exceptions to the geographic standards may be granted if the MCO can demonstrate with specific data that the travel time or distance requirements are not feasible in a particular service area or part of a service area. The following factors are considered:

- Utilization patterns of the existing health care delivery system.

- Financial ability of the MCO to pay charges for health care services that are not provided under contract or by employees of the MCO.
- The MCO's system of documentation of authorized referrals to nonparticipating providers.

11.7 Financial Solvency

To demonstrate financial solvency, MCOs are required by MINN. STAT. § 62D and § 62N to submit the following items:

- A three-year projection of calendar year balance sheets, including admitted assets and liabilities, for the enterprise fund supporting the MCO.
- If an accredited capitated provider is to accept risk for the purpose of reducing the net worth and/or deposit requirements, a copy of the risk agreement, the calculation showing the risk accepted by the accredited capitated provider, and the total risk of the arrangement. A qualified actuarial statement to represent the expected direct costs to an accredited capitated provider for providing the contracted, covered health care services must be submitted.
- If the net worth requirement has been reduced by reinsurance, a copy of the reinsurance, stop-loss or other insurance agreement and evidence of the annual premium must be submitted.
- The source of funds for payment of unexpected services and claims. This source is separate from the source for expected claims and incurred but not reported, predictable claims.
- A three-year projection of calendar year income statements, including projected monthly enrollment.
- A detailed operating plan that includes a three-year projection of the income and expenses for the enterprise fund and other sources of future capital, including projected monthly enrollment.

11.8 MCO Readiness Review

To determine the readiness of an MCO in PMAP expansion counties, DHS relies on three procedures:

- Each MCO with which the State contracts must meet the licensing requirements specified in Minnesota statute, as described above.

- In responding to a DHS PMAP Requests for Proposals, MCO proposing to serve an expansion county must submit data on their network that includes the names and locations

of all providers in the following categories: primary care, hospitals, mental health, dental, chemical dependency, rural health and community clinics, chiropractors, vision care, medical transportation, pharmacies, home health, public health agencies, and FQHCs. DHS staff reviews these proposed networks and works with county staff to determine adequacy and comprehensiveness. In addition, prior to the beginning of client marketing and enrollment in expansion counties, this data will be submitted to HCFA for its review.

- Minnesota statute assures that public health and human services staff from each expansion county review each MCO proposal for their county and make contracting recommendations to DHS. Included in the county's review is an evaluation of the MCO's network in which county staff apply their knowledge of the local health care market. In addition, DHS makes available MA claims payment data that shows where the county's MA population has been obtaining their covered services. This data is used to determine the comprehensiveness and adequacy of access of the MCOs' proposed networks for the county. Any county staff recommendations submitted to the State will be included in material forwarded to HCFA for review.

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11.9 State Agency's Response in the Event of Insolvency of a MCO

The MCO is required to notify its enrollees, in writing, of the date of contract termination and the process by which enrollees will continue to receive medical care. Notification must be at least 60 calendar days in advance of the termination. The notice must be approved by the State, and must include a description of alternatives available for obtaining services after contract termination.

The MCO must assist in the transfer of enrollees' medical records from its participating providers to other providers, upon request and at no cost to the enrollee.

Any funds advanced to the MCO for coverage of enrollees for periods after the contract termination must be promptly returned to the State.

The MCO must promptly supply all information necessary for the reimbursement of any medical claims that result from services delivered after the date of termination.

Written notices must be sent by U.S. Postal Service certified mail, return receipt requested. The required notice periods are calendar days measured from the date the receipt is signed.

Contract termination is effective on the last day of the calendar month in which the notice becomes effective. Payment will continue and services must continue to be provided during that calendar month.

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Section Twelve —Encounter Data

12.1 Minimum Data Set

DHS requires it's contracted MCOs to submit encounter data on all services provided by the MCOs. This data is screened through a multifaceted array of computerized edits that identify incorrect or incomplete submissions. If there are identified inconsistencies in the MCO submitted data it is returned for corrections. The data is stored in DHS's executive information system database that is queried to provide information for a decision support system.

12.2 Data Collection

Data MCOs must maintain. MCOs are required to maintain patient encounter data to identify the physician who delivers services to enrollees, as required by Section 1903(m)(2)(A)(xi) of the Social Security Act, 42 U.S.C. Section 1396b(m)(2)(A)(xi). MCOs must furnish to the State, upon request, in the format determined by and for the time frame indicated by the State, the following information:

1. Individual enrollee-specific, claim-level encounter data for services provided by the MCO to enrollees detailing all medical and dental diagnostic and treatment encounters, all pharmaceuticals, supplies and medical equipment dispensed to enrollees, and all nursing facility services for which the MCO is financially responsible.

2. Claim-level data must be reported using the following claim formats: HCFA 1500 form for physician and professional services; UB92 form for inpatient and outpatient hospital services and nursing facility services; NCPDP form for pharmacy or non-durable medical supplies; and ADA (American Dental Association) form for dental services.

3. All encounter claims must be submitted electronically and must comply with State requirements, including the requirements to submit charge data and to use the standard formats and procedures. Charge data are the lesser of the usual and customary charge (or appropriate amount from a Relative Value Scale for missing or unavailable charges) or submitted charge.

4. MCOs must submit a file of all the providers serving their enrollees, so that the State can issue a State-approved provider identification number to be submitted as required on encounter claims. MCOs may substitute pseudo provider numbers provided by the State in some cases, such as out-of-plan providers of emergency services.

5. MCOs must update provider identification numbers at least quarterly by submitting current and complete provider affiliation and demographic information.

Time to submit data. MCOs must submit encounter claims with all of the required data elements no later than 90 days after date the MCO allowed the claim.

SNF and NF days. MCOs are responsible for submitting claim-level encounter data that distinguishes between skilled nursing facility (SNF) and nursing facility (NF) days.

Codes. Codes must be submitted on encounter data. MCOs must use the following coding sources:

1. Diagnosis codes obtained from the International Classification of Diseases, Clinical Modification (ICD-9-CM).

2. Levels I, II and III procedural codes from the Health Care Financing Administration Common Procedure Coding System (HCPCS) Manual. Level 1 is the Physician's Current Procedural Terminology (CPT). The State will distribute the HCPCS manual to the MCO once per year. The State will provide additional Level III State-related codes in respective service chapters of the Provider Manual.

3. American Dental Association (ADA) codes.

4. National Drug Codes.

5. Codes identified by the STATE in the EDI Specifications Guide for Nursing Facility services.

Remedies if encounter data is not provided. The contract termination section provides remedies if encounter data is not provided by the MCOs. Remedies available to DHS beyond contract termination include partial breach actions such as withholding capitation premiums, monetary fines, and freezing of new enrollment.

12.3 Encounter Data Validation and Decision Support System

The encounter data validation plan provides an outline of the efforts by the Health Program Quality Division to monitor and validate submitted MCO encounter data for public policy and quality management activities. These efforts encompass multiple validation measurement comparisons between the encounter data and HEDIS/performance improvement data sources. Regular periodic validation activities are augmented with independent quality management activities that provide benchmark reference points.

The State's current EQRO study is a concordance study to begin validating encounter data, compared to HEDIS data. The study also involves a separate HEDIS validation for those MCO's

not accredited. In addition, DHS has sent out a RFP to select a vendor to conduct a major validation project for both encounter data and FFS data. A contract is expected to start during calendar year 2001.

As encounter data is validated, it will become available to a Decision Support System that assembles enrollment, utilization, process and outcome results, and satisfaction information to be used for MCO performance evaluation, population based quality improvement baselines, disease management monitoring, utilization and access monitoring.

Overview of annual encounter data validation work plan:

- Quarterly evaluation of submitted data based on edits, volume and MCO comparison criteria.
- Semiannual assessment of divergence from MCO submitted utilization data.
- Annual assessment of divergence from MCO submitted HEDIS data.
- Annual assessment of divergence from medical record data collected in conjunction with EQR studies.

12.4 Encounter Data Use in Quality Improvement

DHS has and will increasingly utilize and monitor encounter type data as a method to longitudinal evaluate and compare MCO access and utilization issues. The Decision Support System will provide greater access to this data and the most immediate use will be in the areas of mental health services and dental care.

12.5 Other Reporting

The MCO must provide the State with the following information in a format and time frame determined by the State:

Births. MCOs must report to the State or the local agency, on a form approved by the State, the birth of any child, within 30 days after the birth of the child. For deliveries performed by non-participating providers, the MCO must report the birth as soon as reasonably possible after the MCO knows of the birth.

Enrollment and marketing materials.

Changes in the service delivery plan. Any substantive changes in the service delivery plan previously submitted within 30 days of the effective date of a contract and prior to any subsequent changes made by the MCO. The State must approve all changes to the MCO's service delivery plan.

Financial Statements and other information as specified by the State to determine the MCO's financial and risk capability.

Quality assurance and improvement information as specified in Section 10.

Complaints and denial, termination, or reduction (DTR) of services information.

MCO administration and subcontracting arrangement information, as specified by the State and HCFA.

Prepaid MCOs - Chemical Dependency Services Client Assessment/Placement A copy of this form (State-3079) must be submitted directly to the State's Chemical Dependency Division within 30 days of the assessment for each enrollee who is assessed for chemical dependency (CD) services. The State will comply with the confidentiality requirements for CD services of 42 C.F.R. Part 2 and Section 1902(a)(27) of the Social Security Act, 42 U.S.C. 1396(a)(27).

Common carrier transportation services policy and procedures. The MCO must annually submit to the State the MCO's policies and procedures, or any changes to such policy or procedures since their last submission to the State.

Prenatal risk assessments and EPSDT/C&TC information.

Provider network data must be submitted within 60 days of request by the State, but not to exceed twice per year.

Additional **third party resources** and all **cost avoided and recovered amounts**.

All **abortions** received by enrollees, including those performed outside of Minnesota, must be reported as an additional or alternative service.

Provider reimbursement methodologies. MCOs must describe in an annual report how they notify enrollees of their provider reimbursement methodologies, including any provider incentives.

MCOs must submit a **Quality Assurance Work Plan**, as described in Section 10.3.4.; and a progress report on meeting 80 percent participation for well-child visits, described in Section 10.2.5.

MCOs must submit their **criteria for mental health inpatient hospital admissions**. The State will assess the average length of stay for inpatient mental health services and review denials of inpatient hospital services and compare denials against encounter and eligibility data to determine how denials of inpatient care and inpatient hospital lengths of stay are related to commitments or

readmissions. The State will also assess what other services are provided to enrollees whose inpatient stays are denied or reduced.

MCOs must submit an annual written report on their approaches to **identifying enrollees in need of mental health and chemical dependency treatment**, as described in Section 8.2.3.